EVERGREEN
PHYSICAL THERAPY

111 SOUTH HUDSON AVE PASADENA, CA 91101
Phone (626) 683 - 8536 Fax (626) 683 - 8236
www.EvergreenPT.net

PATIENT REGISTRATION

Patient's Name _____ Date of Birth ___/___/_____

Guardian (If minor) _____ Relationship _____

Patient's Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Email Address _____

I would like to receive appointment reminders via ☐ Email ☐ Text or ☐ Phone Call

Emergency Contact _____ Phone _____

Relationship to Patient _____

Referring Physician _____ Phone _____

Diagnosis _____

Date of Injury / Onset / Surgery: _____

Was This Related to an Accident? Auto/ Work / Other Date of Accident _____

Have you had prior Physical Therapy, Occupational Therapy, Chiropractic, or Acupuncture visits this year? Yes / No If yes, how many visits? _____

Are you currently, or have you received Home Health Services this year? Home Health services can be, but are not limited to nurse, physical therapy, occupational therapy, wound care, IV or other medication administration. Yes / No

If yes, have you been discharged? Yes / No Date of Discharge _____

* Please note that if you have Medicare and are currently receiving Home Health services, you may not begin outpatient physical therapy without first being discharged from Home Health.

EVERGREEN
PHYSICAL THERAPY

111 SOUTH HUDSON AVE PASADENA, CA 91101
Phone (626) 683 - 8536 Fax (626) 683 - 8236
www.EvergreenPT.net

PEDIATRIC MEDICAL HISTORY

Patient Name _____ Date _____

Please describe the present concerns which brought you to this clinic for care. _____

_____

Date of Birth: ____/____/_____

Referring Diagnosis: _____

Referring Physician: _____

Parent/Guardian name: _____

Birth History

1. Delivery (check any complications) : ☐ Diabetes ☐ Excessive Vomiting
   ☐ Weight Loss ☐ Measles ☐ Bleeding ☐ High Blood Pressure
   ☐ Swelling ☐ Toxemia ☐ Other (please specify)_____
2. Length of pregnancy/ Gestational age _____weeks.
3. Delivery: ☐ Vagina ☐ Cesarean Section
4. Birth Weight _____
5. How long was your child hospitalized following delivery? _____ Discharge date: _____
6. Did your child experience any complications or receive special medical attention? ☐YES ☐NO
7. Was your child ☐Nursed ☐ Bottle Fed?

Medical History

8. Has your child ever been hospitalized or undergone surgery? ☐ YES ☐ NO
9. Does your child have allergies? ☐ YES ☐ NO
10. Please check any of the following that apply to your child:
    - ☐ YES ☐NO Heart condition
    - ☐ YES ☐NO Seizure disorder
    - ☐ YES ☐NO Asthma 493.9
    - ☐ YES ☐NO Frequent ear infections
    - ☐ YES ☐NO Diabetes 250.0
    - ☐ YES ☐NO Hearing impairments
    - ☐ YES ☐NO Visual impairments
    - ☐ YES ☐NO Difficulty in swallowing/eating
    - ☐ YES ☐NO Dermatitis/ Eczema rash
    - ☐ YES ☐NO Congenital deformities
    - ☐ YES ☐NO Irregular sleep habits
    - ☐ YES ☐NO Persistent irritability

EVERGREEN PHYSICAL THERAPY
111 SOUTH HUDSON AVE PASADENA, CA 91101
Phone (626) 683 - 8536 Fax (626) 683 - 8236
www.EvergreenPT.net

☐ YES ☐NO Withdrawn or isolated behavior
☐ YES ☐NO Markedly limited attention span
☐ YES ☐NO Other_____

11. Is your child on prescribed medications? ☐YES ☐NO
12. Please list all physicians involved in your child's care and specify for what medical condition:

_____
_____

Developmental History

1. Please note the appropriate ages at which your child accomplished the following milestones:
   a. Rolled from stomach to back _____months
   b. Reached for objects _____months
   c. Rolled from back to stomach _____months
   d. Crawled on stomach _____months
   e. Sat independently _____months
   f. Crawled on hands and knees _____months
   g. Walked independently _____months
2. When did you begin having concerns regarding your child's development?

_____
_____
_____

3. Please list your current concerns regarding your child's development: _____

_____
_____
_____

4. Has your child ever received ☐ Occupational Therapy ☐ Physical Therapy?
   Please explain prior treatment and response: _____

_____
_____

5. Does your child currently receive school based ☐ Occupational Therapy ☐ Physical Therapy?
   Please list frequency, name of school, and therapist:_____

_____
_____

6. What would you like to accomplish with therapy? _____

_____

EVERGREEN
PHYSICAL THERAPY

PATIENT NAME:_____

_____ *Consent for Care and Treatment*

I, the undersigned, hereby agree and give my consent for above named practice to furnish care and treatment considered necessary and proper in treating my condition.

_____ *Authorization for Signature on File and release of Information*

I, the undersigned, hereby authorize the office of above named practice to affix my name to any and all claims or documents as related to any and all health benefits due me. I authorize the release of any information relating to my health care claims. A photo copy of this authorization shall be as valid as an original.

_____ *Authorization for Assignment of Benefits*

I, the undersigned, hereby assign all medical benefits, to which I am entitled to the office of above named practice, and I shall be financially responsible for any unpaid balance. In the event payment is made directly to me for services rendered by this office, I recognize the obligation to promptly remit payment to this office. I hereby authorize and instruct my insurance company to pay directly to the above named practice.

_____ *Financial Responsibility*

I, the undersigned, understand and agree that if it becomes necessary to commence legal action, I am responsible for all costs of collecting moneys owed including court costs, collection agency fees and attorney fees, in addition to my outstanding account balance. I further understand that balances over 60 days will be subject to a 1.5% finance charge, for which I am personally liable.

_____ *Notice of Privacy Practices*

I have read and fully understand the named practice's Notice of Practices. I understand that the above named practice may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that the above named practice will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in the above named practice's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

Patient or Guardian Signature **Date**

Evergreen Physical Therapy Specialists, Inc.
Coronavirus Disease 2019
Non-Personnel Questionnaire

If you have been fully vaccinated for two or more weeks, please indicate below your name at the bottom of this form.

All non-personnel (patients, visitors, vendors, etc.) will be asked to complete this form or to verbally attest to the questions posed on each in-person visit. A daily log will be maintained to record verbal attestations.

Please check the **Yes** or **No** boxes; do not check both the yes and no boxes.

1. Have tested positive for COVID-19 in the past 10 days? Yes ☐ No ☐
2. Are you currently awaiting results from a COVID-19 test? Yes ☐ No ☐
3. Have you been diagnosed with COVID-19 by a licensed health care provider in the past 10 days? Yes ☐ No ☐
4. Have you been told that you are suspected to have COVID-19 by a licensed health care provider in the past 10 days? Yes ☐ No ☐
5. Have you had any of these symptoms in the past 48 hours?

Fever over 100.4° or chills	Yes ☐ No ☐
Persistent cough	Yes ☐ No ☐
Shortness of breath/difficulty in breathing	Yes ☐ No ☐
Fatigue	Yes ☐ No ☐
New loss of taste or smell	Yes ☐ No ☐
Sore throat	Yes ☐ No ☐
Muscle or body aches	Yes ☐ No ☐
Congestion or runny nose	Yes ☐ No ☐
Nausea or vomiting	Yes ☐ No ☐
Diarrhea	Yes ☐ No ☐
Headaches	Yes ☐ No ☐

In order to comply with OSHA's Emergency Temporary Standard for exempt outpatient providers we are prohibited from allowing COVID-19 positive or suspected positive individuals from entering our facility past our screening point. We will make every attempt to provide patient treatments via telehealth, in these situations if permitted by law. Should this not be available we will provide a list of potential facilities that may be available for continued treatment during this restriction period.

Name: _____ Date: _____

Vaccinated: Yes ☐ No ☐

This Information is Highly Confidential & Will be Securely Managed