



**EVERGREEN**  
PHYSICAL THERAPY

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**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.



MEDICAL HISTORY

PATIENT NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

\*HEIGHT: \_\_\_\_\_ \*WEIGHT: \_\_\_\_\_ ONSET DATE OF INJURY: \_\_\_\_\_

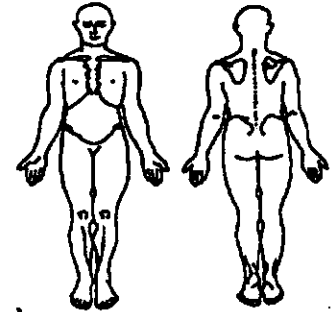
CONDITION/TYPE OF INJURY OR CAUSE: \_\_\_\_\_  
(Is this due to an auto accident?)

TYPE OF SURGERY & DATE \_\_\_\_\_

HAVE YOU HAD ANY IMAGING PERFORMED:

- X-Ray, MRI, CT SCAN, Ultrasound

Date of Imaging: \_\_\_\_\_



PLEASE MARK AREA(S) OF CONCERN

HAVE YOU RECENTLY NOTED:

- Weight Loss/Gain, Weakness, Pregnant/IUD, Pain at Night, Nausea/Vomiting, Fever/Chills/Sweats, Headaches, Leg Cramps when Walking, Fatigue, Numbness/Tingling, Change in Vision/ Hearing, Insomnia

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- Surgeries, Sprains/ Strains, Heart Problems, Circulation/ Clots, Fainting, Difficulty Swallowing, Loss of Consciousness, Diabetes, Cancer, Asthma/ Breathing Problems, Easy Bruising/Bleeding, Osteoporosis, Fractures, Blood Pressure Problems, Arthritis, Lung Disease, Leg/Ankle Swelling, Urinary Problems/Infections

EXPLAIN AND GIVE APPROXIMATE DATES FOR ANY ITEMS INDICATED ABOVE: \_\_\_\_\_

\_\_\_\_\_

\*TYPE OF ALLERGIES (IF ANY): \_\_\_\_\_

Table with 3 columns: \*LIST OF CURRENT MEDICATIONS, \*DOSE, \*FREQUENCY

(IF MORE SPACE IS NEEDED, PLEASE LIST ON THE BACK)

\*Are you taking VITAMIN D? YES NO

\*Describe the pain in the last 24 hours: DURING ACTIVITY DURING REST (SCALE OF 1-10)

What makes the pain better or worse? \_\_\_\_\_

\*Have you had 2 or more FALLS within the last 12 months? YES NO

\*Have you had at least one FALL WITH AN INJURY in the last 12 months? YES NO

What are your goals for Physical Therapy? (PLEASE USE BACK OF FORM)

X \_\_\_\_\_ PATIENT OR AUTHORIZED SIGNATURE

\_\_\_\_\_ DATE



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**