Patient Registration

Patient Information:

First Name	MI	Last Name	
DOB	Age	Gender	SSN
Address	City	State	Zip
Cell Phone	Other Phone (optional)		
Email Address			

For my convenience, I agree that my therapist may communicate and use Protected Health Information with me via the following unencrypted message types (check all that apply):

☐ Voice Mail ☐ Text Message ☐ Email

Emergency Contact:

Name	Phone	Relationship to Patient

Insurance Information:

Is the patient the primary member of the health plan? ☐ Yes ☐ No (Complete the following)

Primary Member's Full Name	Primary Member's DOB	Relationship to Patient

☐ Check this box if you have provided a photocopy of your health insurance card(s), and skip the following.

Primary Insurance Plan	Member ID	Group #
Secondary Insurance Plan (if any)	Member ID	Group #

Billing Information:

☐ Check this box if the billing name, address, and phone are the same as the patient's above, and skip this section.

Name		Phone	
Address	City	State	Zip

By signing below, I confirm that the above information is true and accurate.

Patient/Guardian	Date

Medical History

Name: ______________________________ Date: ____________

You	Family	Condition
(Check all that apply)		
☐	☐	Heart Disease
☐	☐	High Blood Pressure (Hypertension)
☐	☐	Low Blood Pressure (Hypotension)
☐	☐	Pneumonia
☐	☐	Asthma
☐	☐	Concussion/Head Injury
☐	☐	Vertigo/Dizziness
☐	☐	Osteoarthritis
☐	☐	Rheumatoid Arthritis
☐	☐	Osteoporosis/Osteopenia
☐	☐	Gout
☐	☐	Cancer
☐	☐	Infectious Disease
☐	☐	Thyroid Disease
☐	☐	Seizures
☐	☐	Stroke/CVA/TIA
☐	☐	Blood Clots/DVT
☐	☐	Vascular Disease
☐	☐	Diabetes
☐	☐	Fibromyalgia
☐	☐	Other condition(s):______________________

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Surgical History	Year Undergone
______________________	____________
______________________	____________
______________________	____________

Cigarette Smoking: ☐ Current ☐ Used to ☐ Never

Acknowledgement Form

Consent to Undergo Physical Therapy Evaluation and Treatment

I hereby consent to evaluation and treatment of my condition by a licensed physical therapist employed by or under contract with Spirit Physical Therapy (DBA for Friedrichs Physical Therapy, LLC). I understand that the benefits of treatment may include decreased pain, increased mobility, and improved function, but that no guarantee of such results can be made. Furthermore, I understand that the risk of physical therapy treatment includes possible musculoskeletal discomfort and, although unlikely, further irritation of the condition for which I am seeking treatment, or any other condition I may have. I understand that I will have the opportunity to have all of my questions answered by my physical therapist prior to undergoing any treatment.

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Patient / Guardian Signature

Privacy Policy and Limited Use of Protected Health Information

I acknowledge that I may request a copy of the Spirit Physical Therapy Privacy Policy at any time. I hereby authorize Spirit Physical Therapy to disclose and/or receive my (or my dependent's) Protected Healthcare Information for the sole purposes of treatment, payment, or healthcare operations, unless otherwise instructed in writing by me.

____
Patient / Guardian Signature

Waiver and Release

I hereby release Spirit Physical Therapy, and its employees and affiliates, from all liability, claims, demands, or causes of action related to 1) loss or damage of my personal belongings 2) my refusal to accept or allow emergency medical services, including but not limited Emergency Medical Technician care and ambulance transport.

____
Patient / Guardian Signature

Authorization of Payment and Financial Agreement

I hereby assign all health insurance reimbursements directly to Friedrichs Physical Therapy, LLC (DBA Spirit Physical Therapy) for physical therapy services rendered to me. I agree that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. I agree that I will be responsible for non-covered charges, including those for disbursed rehabilitation equipment and a $25.00 fee for each no-show appointment. I further agree that if my account becomes delinquent, I may be assessed a late fee of 10% or $15.00, whichever is greater, and that my account may be forwarded to a collections agency and/or reported to a credit bureau.

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Patient / Guardian Signature

____ ____________________
Printed Name Date

Modified Oswestry

Name: ____ Date: ________________

This questionnaire has been designed to give your therapist information as to how your back pain has affected your ability to manage everyday life. Please answer every question by placing a mark in the one box that best describes your condition today. We realize you may feel that 2 of the statements may describe your condition, but **please mark only the box that most closely describes your current condition.**

1. Pain Intensity

☐ I can tolerate the pain I have without having to use pain medication.
☐ The pain is bad, but I can manage without having to take pain medication.
☐ Pain medication provides me with complete relief from pain.
☐ Pain medication provides me with moderate relief from pain.
☐ Pain medication provides me with little relief from pain.
☐ Pain medication has no effect on my pain.

2. Personal Care (e.g., Washing, Dressing)

☐ I can take care of myself normally without causing increased pain.
☐ I can take care of myself normally, but it increases my pain.
☐ It is painful to take care of myself, and I am slow and careful.
☐ I need help, but I am able to manage most of my personal care.
☐ I need help every day in most aspects of my care.
☐ I do not get dressed, I wash with difficulty, and I stay in bed.

3. Lifting

☐ I can lift heavy weights without increased pain.
☐ I can lift heavy weights, but it causes increased pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, i.e. on a table).
☐ Pain prevents me from lifting heavy, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift only very light weights.
☐ I cannot lift or carry anything at all.

4. Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than 1 mile.
☐ Pain prevents me from walking more than 1/2 mile.
☐ Pain prevents me from walking more than 1/4 mile.
☐ I can walk only with crutches or a cane.
☐ I am in bed most of the time and have to crawl to the toilet.

5. Sitting

☐ I can sit in any chair as long as I like.
☐ I can only sit in my favorite chair as long as I like.
☐ Pain prevents me from sitting for more than 1 hour.
☐ Pain prevents me from sitting for more than 1/2 hour.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ Pain prevents me from sitting at all.

6. Standing

☐ I can stand as long as I want without increased pain.
☐ I can stand as long as I want, but it increases my pain.
☐ Pain prevents me from standing for more than 1 hour.
☐ Pain prevents me from standing for more than 1/2 hour.
☐ Pain prevents me from standing for more than 10 minutes.
☐ Pain prevents me from standing at all.

7. Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using pain medication.
☐ Even when I take medication, I sleep less than 6 hours.
☐ Even when I take medication, I sleep less than 4 hours.
☐ Even when I take medication, I sleep less than 2 hours.
☐ Pain prevents me from sleeping at all.

8. Social Life

☐ My social life is normal and does not increase my pain.
☐ My social life is normal, but it increases my level of pain.
☐ Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
☐ Pain prevents me from going out very often.
☐ Pain has restricted my social life to my home.
☐ I have hardly any social life because of my pain.

9. Traveling

☐ I can travel anywhere without increased pain.
☐ I can travel anywhere, but it increases my pain.
☐ My pain restricts my travel over 2 hours.
☐ My pain restricts my travel over 1 hour.
☐ My pain restricts my travel to short necessary journeys under 1/2 hour.
☐ My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment/Homemaking

☐ My normal homemaking/job activities do not cause pain.
☐ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
☐ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (e.g., lifting, vacuuming).
☐ Pain prevents me from doing anything but light duties.
☐ Pain prevents me from doing even light duties.
☐ Pain prevents me from performing any job or homemaking chores.