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):_____
		_____

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.

_____

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.

_____

Patient / Guardian Signature

_____ _____

Printed Name Date

Neck Disability Index

Name: _____ Date: _____

This questionnaire has been designed to give your therapist information as to how your neck 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 have no pain at the moment.
☐ The pain is very mild at the moment.
☐ The pain is moderate at the moment.
☐ The pain is fairly severe at the moment.
☐ The pain is very severe at the moment.
☐ The pain is the worst imaginable at the moment.

2. Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but can 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 stay in bed.

3. Lifting

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

4. Reading

☐ I can read as much as I want to with no pain in my neck.
☐ I can read as much as I want to with slight pain in my neck.
☐ I can read as much as I want with moderate pain in my neck.
☐ I can't read as much as I want because of moderate pain in my neck.
☐ I can hardly read at all because of severe pain in my neck.
☐ I cannot read at all.

5. Headaches

☐ I have no headaches at all.
☐ I have slight headaches, which come infrequently.
☐ I have moderate headaches, which come infrequently.
☐ I have moderate headaches, which come frequently.
☐ I have severe headaches, which come frequently.
☐ I have headaches almost all the time.

6. Concentration

☐ I can concentrate fully when I want to with no difficulty.
☐ I can concentrate fully when I want to with slight difficulty.
☐ I have a fair degree of difficulty concentrating when I want to.
☐ I have a lot of difficulty concentrating when I want to.
☐ I have a great deal of difficulty concentrating when I want to.
☐ I cannot concentrate at all.

7. Work

☐ I can do as much work as I want to.
☐ I can only do my usual work, but no more.
☐ I can do most of my usual work, but no more.
☐ I cannot do my usual work.
☐ I can hardly do any work at all.
☐ I can't do any work at all.

8. Driving

☐ I can drive my car without any neck pain.
☐ I can drive my car as long as I want with slight pain in my neck.
☐ I can drive my car as long as I want with moderate pain in my neck.
☐ I can't drive my car as long as I want because of moderate pain in my neck.
☐ I can hardly drive at all because of severe pain in my neck.
☐ I can't drive my car at all.

9. Sleeping

☐ I have no trouble sleeping.
☐ My sleep is slightly disturbed (less than 1 hr sleepless).
☐ My sleep is mildly disturbed (1-2 hrs sleepless).
☐ My sleep is moderately disturbed (2-3 hrs sleepless).
☐ My sleep is greatly disturbed (3-5 hrs sleepless).
☐ My sleep is completely disturbed (5-7 hrs sleepless).

10. Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all.
☐ I am able to engage in all my recreation activities, with some pain in my neck.
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck.
☐ I can hardly do any recreation activities because of pain in my neck.
☐ I can't do any recreation activities at all.