INSHAPE
PHYSICAL THERAPY AND WELLNESS CENTER, LLC

Registration and History

Patient Information

Date:_____ SSN:_____

Patient Name: (Last) (First) (MI)

Address:

City: State: Zip:

Email: Occupation:

Employer / School: Address:

City: State: Zip: Phone: ( )

Sex: ◯ Male ◯ Female Date of Birth: _____ Age: _____

◯ Married ◯ Widowed ◯ Single ◯ Minor ◯ Separated ◯ Divorced ◯ Partnered for _____ years.

Spouse's Name: Birth date: SSN:

Spouse's Employer:

Whom may we thank for referring you?

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and
Name of Insurance Company(ies)
assign directly to ***IN***SHAPE Physical Therapy and Wellness Center, LLC. all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

INSHAPE Physical Therapy and Wellness Center, LLC. May use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed and resulting charges are paid or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian, or Personal Representative

_____
Please print name of Patient, Parent, Guardian, or Personal Representative

_____
Date Relationship to Patient

Phone Numbers

Home Phone: ( ) Cell: ( ) Best time and place to reach you:

IN CASE OF EMERGENCY, CONTACT: Name:

Home Phone: ( ) Cell: ( ) Work: ( )

Accident Information

Is condition due to an accident? ◯ Yes ◯ No Date:_____ Type of accident: ◯ Auto ◯ Work ◯ Home ◯ Other

To whom have you made a report of your accident? ◯ Auto Insurance ◯ Employer ◯ Workers Comp. ◯ Other

Attorney Name (if applicable):_____ Phone: (_____)_____

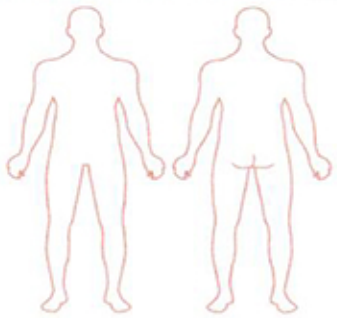
Patient Condition

Reason for Visit:_____

When did your symptoms appear?_____

Is this condition getting progressively worse? ◯ Yes ◯ No ◯ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling. → → → →



Rate the severity of your pain on a scale from 0 (no pain) to 10 (severe pain):_____

Type of Pain: ◯ Sharp ◯ Dull ◯ Throbbing ◯ Numbness ◯ Aching ◯ Shooting

How often do you have this pain?____ Is it ◯ constant or ◯ does it come and go.

Does it interfere with your: ◯ Work ◯ Sleep ◯ Daily Routine ◯ Recreation

Painful activities or movements: ◯ Sitting ◯ Standing ◯ Walking ◯ Bending ◯ Lying Down

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Health History

What treatment have you already received for your condition? ◯ Medications ◯ Surgery ◯ Physical Therapy ◯ Chiropractic Services ◯ Other:_____

Name and address of other doctor(s) who have treated you for your condition:_____

Date of Last:

Physical Exam:	Spinal X-Ray:	Blood Test:
Spinal Exam:	Chest X-Ray:	Urine Test:
Dental X-Ray:	MRI, CT-Scan, Bone Scan:	

Please a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS / HIV	◯ Yes	◯ No	Diabetes (I)	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Rheumatoid Arthritis	◯ Yes	◯ No
			Diabetes (II)	◯ Yes	◯ No						
Alcoholism	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	Measles	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Allergy Shots	◯ Yes	◯ No	Epilepsy	◯ Yes	◯ No	Migraines	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Fractures	◯ Yes	◯ No	Miscarriage	◯ Yes	◯ No	Sexually Trans. Disease	◯ Yes	◯ No
Anorexia	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Mononucleosis	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Appendicitis	◯ Yes	◯ No	Goiter	◯ Yes	◯ No	Multiple Sclerosis	◯ Yes	◯ No	Suicide Attempt	◯ Yes	◯ No
Arthritis	◯ Yes	◯ No	Gonorrhea	◯ Yes	◯ No	Mumps	◯ Yes	◯ No	Thyroid Problems	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Gout	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Bleeding Disorders	◯ Yes	◯ No	Heart Disease	◯ Yes	◯ No	Pacemaker	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Breast Lump	◯ Yes	◯ No	Hepatitis Type:_____	◯ Yes	◯ No	Parkinson's Disease	◯ Yes	◯ No	Tumors, Growths	◯ Yes	◯ No
Bronchitis	◯ Yes	◯ No	Hernia	◯ Yes	◯ No	Pinched Nerve	◯ Yes	◯ No	Typhoid Fever	◯ Yes	◯ No
Bulimia	◯ Yes	◯ No	Herniated Disk	◯ Yes	◯ No	Pneumonia	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Polio	◯ Yes	◯ No	Vaginal Infections	◯ Yes	◯ No
Cataracts	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Prostate Problem	◯ Yes	◯ No	Whooping Cough	◯ Yes	◯ No
Chemical Dependency	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Prosthesis	◯ Yes	◯ No	Other: _____		
Chicken Pox	◯ Yes	◯ No	Kidney Disease	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No			

Have you had Physical Therapy in the past 12 months? ◯ Yes ◯ No **If yes, how many visits did you have?** _____

Exercise
- ◯ None
- ◯ Moderate
- ◯ Daily
- ◯ Heavy

Work Activity
- ◯ Sitting
- ◯ Standing
- ◯ Light Labor
- ◯ Heavy Labor

Habit
- ◯ Smoking — Packs/Day:
- ◯ Alcohol — Drinks/Week:
- ◯ Coffee/Caffeine Drinks — Cups/Day:
- ◯ High Stress Level — Reason:

Are you pregnant? ◯ Yes ◯ No Due Date:_____

Injuries/Surgeries:	Description:	Date:
--Falls:		
--Head Injuries:		
--Broken Bones:		
--Dislocations:		
--Surgeries:		

Medications	Allergies	Vitamins/Herbs/Minerals
Pharmacy Name:		
Pharmacy Phone: ( )		

/NSHAPE

PHYSICAL THERAPY AND WELLNESS CENTER, LLC

Company Policies and Patient Rights

- SHAPE Physical Therapy and Wellness Center, LLC will provide faith-based physical therapy and wellness services with the highest quality care.
- SHAPE Physical Therapy and Wellness Center, LLC reserves the right to change company policies, business hours, and patient rights at any time.
- All patients reserve the right to refuse and/or stop treatment at any time upon request.
- All patients reserve the right to view their own medical records at any time upon request.
- All patients and all guests will respect the facility and all company policies. The involved patient and/or guest will be held financially responsible for replacing and/or repairing any damaged or contaminated equipment/supplies including labor costs.
- All guests will be responsible for their own safety during their visit at SHAPE Physical Therapy and Wellness Center, LLC.
- Patients and all guests will be fully responsible for the safety and wellbeing of any children who accompany them.
- Patients and all guests must have the permission of the therapist to handle any therapeutic equipment and/or supplies.
- All patients will be provided with "INPUT" quality assessment forms to provide comments/suggestions/complaints upon request.
- All patients are responsible for supplying any additional supplies needed for personal care including medications/equipment.
- All patients are responsible for communicating any changes in health status or insurance coverage to the therapist immediately to ensure updated health information.
- All patients will be held responsible for obtaining current insurance coverage and benefits, including deductibles and financial responsibilities for all services. All deductibles, co-payments, and other applicable fees are to be paid in full at/before time of service. No exceptions.
- All patients will be held financially responsible for the $25.00 fee for each missed, re-scheduled, or cancelled appointment made less than 24 hours from the appointment time. No exceptions.
- SHAPE Physical Therapy and Wellness Center, LLC reserves the right to remove any/all future appointments following three missed or cancelled appointments.
- These Policies & Procedures are in place to help you achieve your goals in a timely and effective manner.

Please sign below to Indicate knowledge and agreement to comply to all policies and procedures stated above:

Patient Name:_____**Date:**_____

Patient/Caregiver Signature:_____**Date:**_____

Witness Signature:_____**Date:**_____