900 Stanhope Gardens, Suite 101 Chesapeake, VA 23320
Phone: 757.842.6562 Fax: 757.842.6563 www.RPTwellness.com

New Patient Registration

Name ______________________ **Home #** ______________ **Cell #**______________

DOB ____________ **Social Security #** ______________ **Email** ______________________

☐ **I give permission to contact me via email for appointments, general questions, and clinic news and updates.**

Patient's Address ______________________ **City** __________ **State** ____ **Zip** ______

Employment ______________________ **Occupation** ______________________

Who is your Primary Care Physician? ______________________ **Phone Number** ____________

Which Doctor referred you to RPT? ______________________ **Phone Number** ____________

How did you hear about Restorative Physical Therapy? ______________________

Emergency Contact ______________________ **Phone** ____________ **Relationship** __________

Spouse or Legal Guardian

Name ______________________ **Relationship** ______________ **Email** ______________

Home Phone ______________ **Cell Phone** ______________ **Work** ______________

Patient's Address ______________________ **City** __________ **State** ____ **Zip** ______

Employment ______________________ **Occupation** ______________________

Injury

Related to an accident or injury? Yes No **Date of injury** ________ **Nature of injury** ______________

Is this related to an auto accident? Yes No **Date of accident** __________ **State of accident** __________

Is there an attorney involved? Yes No **Name** ______________________ **Phone** ______________

Is this injury relation to a Workers Compensation case? Yes No **Date of Injury** ________ **File Number** ________

Workers Compensation Carrier ______________________ **Phone Number** ______________

Point of Contact ____

Insurance

	Primary	**Secondary**
Insurance Name		
Member ID Number		
Subscriber Name		
Relationship to Subscriber		
Subscriber SSN		
Subscriber Date of Birth		

Patient Signature ______________________________ **Date** ______________________

Health Intake Form

Patient Name: ____ DOB: ___________ Date:_________________
Height:______ Weight:______ Age:_____

Please complete the following information in detail. This will assist us in designing the most effective and efficient individualized program for you. Every item is significant. Please print neatly.

Who recommended you to this clinic?

____

Official Diagnosis/Main Problem:

____

List main complaints/challenges in order of importance:

____
____

When did pain begin (weeks/months/years)?:

____

Describe current area of pain AND type of pain (aching, numbness, tingling, burning: ____________________________
____
____

What makes pain worsen?

____
____

What makes pain decrease?

____
____

Special tests (X-rays, MRIs, etc.):

____
____

Current medications/dosages, over the counter medicines, vitamins/supplements:____________________
____
____
____
____
____
____

Are you currently receiving occupational or speech therapy, chiropractic care, or home health care?: _________________
____

Surgeries:____
____
____

Injuries:____
____
____

Major/Minor Illnesses:_________________________________
____
____

Any history of falls in the last year?:_________________________
____

Present Activity
How many hours do you sleep at night?:______________________

How many hours per day do you spend in bed?:________________

How would you rate your present level of activity?:
€ Poor € Fair € Good

Please list your present hobbies:_____________________________
____

Current Work Status and History
Please state what you do for a living:________________________
____

How many hours do you work per week?:_____________________

If not working, how long have you not worked?:_______________

Do you receive compensation (disability insurance)?: Yes No

If not, are you considering or have you applied for compensation o any kind?:____

If you anticipate returning to work, when do you hope to do so?:
____

Home Environment
Please list any current assistive devices (cane, walker, etc):
____

Present home environment (railings, ramps, bathroom modifications, etc):____________________________________
____

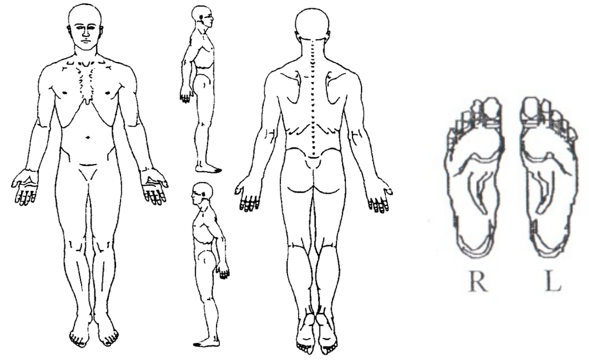
Are you losing weight without trying: Yes No

Are you coughing up blood/noticing it in urine/stool: Yes No

Circle the level of pain you are experiencing (1=lowest):

1 2 3 4 5 6 7 8 9 10

Pain Diagram: please shade all areas of pain



Health Habits
€ Tobacco € Alcohol € Caffeine € Soda

How often do exercise per week:___________________________

What type of activities do you do for exercise:________________

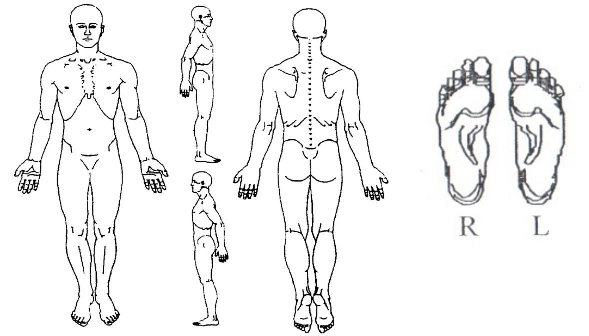
Nutrition and Diet:
Any specific diet/food allergies? ______________________________

Circle the level of stress you are experiencing (1=lowest)
1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (changes in job/residence, finances, legal problems):
____

While you are here at Restorative Physical Therapy a goal list will help us recognize what you would like to accomplish. Your therapist will evaluate you with your input in mind. Goals will be revised as needed. Please fill in the blanks below, answering the question
"I know I will be better when I can…."
1.____
2.____
3.____

Parasthesia Diagram: Please shade areas of "funny feeling" (tingling, burning, pins and needles, etc)



- Alcoholism
- Allergies
- Alzheimer's Disease
- Arthritis
- Asthma
- Attention Deficit Disorder (ADD)
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autoimmune Disease type_________________
- Back Pain
- Bronchitis
- Cancer type_________________
- Carpal Tunnel Syndrome
- Cerebral Palsy
- Cholesterol (elevated)
- Chronic Fatigue Syndrome
- Circulatory Problems
- Colitis
- Dental Problems
- Depression
- Diabetes
- Diverticular Disease
- Drug Addiction
- Eating Disorder
- Epilepsy
- Environmental Sensitivities
- Eyes/ears/nose/throat problems
- Facial Palsy
- Fibromyalgia

- Food Intolerance
- Gastrointestinal Problems
- Genetic Disorder type_________________
- Glaucoma
- Gout
- Headaches
- Heart Disease
- High Blood Pressure
- Infection, chronic
- Inflammatory Bowel Disease
- Irritable Bowel Syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Lymphedema
- Lymphatic Problems
- Mental Illness
- Intellectual
-
- Mononucleosis
- Multiple Sclerosis
- Musculoskeletal problems
- Obesity
- Osteoporosis
- Paraplegia
- Parkinson's
- Phobias
- Pneumonia
- Quadriplegia
- Respiratory problems
- Rheumatoid Arthritis

- Seasonal Affective Disorder
- Sinus Problems
- Skin Problems
- Spina Bifida
- Stroke
- Thyroid Disease/Trouble
- Traumatic Brain Injury (TBI)
- Tuberculosis
- Ulcer
- Urinary Tract Infection
- Varicose Veins
- Other

Medical (Men):

- Benign Prostatic Hypertrophy
- Decreased sex drive
- Infertility
- Prostate Cancer
- Sexually Transmitted Disease
- Other_____________________

Medical (Women):

- Breast Cancer
- Breast surgery
- Decreased sex drive
- Endometriosis
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Infertility
- Menstrual irregularities
- Pelvic Inflammatory Disease
- PMS
- Sexually Transmitted Disease
- Vaginal Infections
- Other

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AUTHORIZATION FOR TREATMENT

I hereby authorize evaluation and treatment by Restorative Physical Therapy on behalf of myself and/or my minor children, including stepchildren.

RELEASE OF INFORMATION

I hereby authorize the release of any and all medical and/or changes information as is necessary for third party reimbursement from any insurance payer or government agency involved in the payment of my treatment.

OBLIGATION OF PAYMENT

I direct and assign payment from my insurance company to Restorative Physical Therapy. I understand that I am ultimately responsible for payment of the entire bill for medical goods or services provided to my children or me and that my insurance policy is a contract between my insurance company and me. I shall pay any deductible and/or co-payment at the time of service. This amount is an estimate of the portion of the fee that is not covered by insurance.

I will advise Restorative Physical Therapy immediately of any changes in insurance coverage or my address.

If I am choosing to seek physical therapy from Restorative Physical Therapy as an out-of-network provider, I will be given the option of a self pay fee of $100 . We accept cash/credit/check payment.

PAST DUE BALANCES AND PROCEDURES FOR COLLECTION

If payment from my insurance company is not received within 90 days, my account will be due and payable in full by me. Any balance remaining on the account after insurance pays will be due upon receipt of my statement. If a self pay client (i.e. RPT does not take my insurance or my insurance benefits for P.T. are capped out for the year), I will pay the amount in full at time of appointment.

If prompt payment is not made, I understand that Restorative Physical Therapy may immediately take action to collect its charges and any outstanding balance. I agree to pay all costs and expenses incurred by Restorative Physical Therapy for collecting any amounts I owe, including court costs and thirty-three and one third percent attorney fees of any outstanding balance. Additionally, I understand that a fee of $25.00 will be applied to my account for any returned checks.

CELL PHONE USE POLICY

At Restorative Physical Therapy, our patients are at the center of everything we do. Among our many priorities, we value and respect the privacy of our patients, our visitors, and our staff. Patients and visitors are welcome to use personal devices in the lobby and outside the practice. No cell phone use is permitted in the treatment area or in treatment rooms. We appreciate your cooperation and ask you to follow them while at RPT.

Please be considerate of those around you when using your mobile devices. Remember that others may overhear your conversations and that you may not have an expectation of privacy. Use low, quiet voices, and do not act in a disruptive or disrespectful manner.

ACKNOWLEDGEMENTS

I, the Patient/Guardian, acknowledge that I was given an opportunity to ask questions about the information provided in this form. My signature is acknowledgment of my understanding of and agreement with the provision of this agreement.

Patient/Guarantor signature: ____ Date: ______________________

Witness signature: ____ Date: ________________________

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Attendance Policy

Dear Valued Patient:

Please be aware of the following attendance policy created to best serve you and all of our patients. We look forward to providing quality care for you, and to aid in maximizing benefits from therapy, we need your full participation.

1. Please arrive on time for your scheduled appointment. Please call if you will be more than 10 minutes late. If you are more than **15 minutes** late for your appointment, we may be required to reschedule.
2. Please call 24 hours in advance if you know you have to cancel an appointment. We understand emergencies do happen, so in these instances please call as soon as possible to cancel your appointment.
   Restorative Physical Therapy reserves the right to assess a $95.00 fee for cancellations with less than 24 hours notification and a $95.00 fee for all no shows to our office.
3. We will have to remove you from our schedule after 3 consecutive cancellations or 2 “no-shows.” This may require you to return to the doctor before coming back to therapy. Your doctor will be made aware of cancellations and “no-shows.”
4. We are generally flexible with our ability to reschedule appointments. Please call us as soon as you know that you have a conflict in your schedule and we will try our best to accommodate your needs.
5. Physical therapy is covered under medical necessity on most insurance policies and therefore we must see you **on a weekly basis**. If you are unable to abide by this policy then we will have to remove you from our schedule.

Acknowledgement of receipt of Notice of Privacy Practices

By default, no other persons may have access to my medical records except the following people:

Name: ______________________________ Relationship: ________________________________

Name: ______________________________ Relationship: ________________________________

I authorize RPT to contact me, and leave messages, regarding my Physical Therapy care and/or appointments on the following numbers:

Home: _________________________ Cell: __________________________ Work: ____________________

I have read and understand the above attendance policy and Privacy Practices were reviewed.

Signature:______________________________ Date: _______________________________