******

***Healing Star Physical Therapy Patient Registration Form***

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**First Last MI**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: M F**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street City State Zip Code**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any prior therapy this year? Yes No**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Work Status:** Full Time Part Time Disabled

**Primary Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Secondary Insurance Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Policy# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this injury as a result of a Motor Vehicle Accident or any Liability? YES / NO (Please Circle)**

**Date of Accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Car Insurance or Workers Comp Carrier: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Policy # **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Attorney Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Case Manager Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient, please initial here is the above information is complete and correct: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Intake completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History Form**

*By taking the time to complete this form, you will be assisting us in planning your physical therapy treatment. Please be as thorough as possible. If there is information relevant to your treatment not outlined below, please bring it to the attention of your physical therapist. Your cooperation is greatly appreciated.*

**Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diagnosis as stated by physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did this injury/exacerbation occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever been hospitalized for the present condition? Yes. No If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had surgery for the present condition? Yes No If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If yes, surgery type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had any falls this past year? Yes No If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you received previous treatment for this condition? Yes No. If yes, date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If yes, please summarize: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever had any of the following? EMG CT Scan MRI X-Ray**

**Have you ever, or are you presently being treated for any of the following conditions?**

|  |  |  |
| --- | --- | --- |
| Acquired Respiratory Distress Syndrome | Yes | No |
| Angina | Yes | No |
| Anxiety | Yes | No |
| Arthritis (RA, OA) | Yes | No |
| COPD | Yes | No |
| Congestive Heart Failure | Yes | No |
| Degenerative Disc Disease | Yes | No |
| Depression | Yes | No |
| Diabetes | Yes | No |
| Hearing Impairment | Yes | No |
| Heart Attack | Yes | No |
| Multiple Sclerosis | Yes | No |
| Osteoporosis | Yes | No |
| Parkinson’s Disease | Yes | No |
| Peripheral Vascular Disease | Yes | No |
| Visual Impairment | Yes | No |
| Allergies | Yes | No |
| Headaches | Yes | No |
| Back Injury | Yes | No |
| Bleeding Disorders | Yes | No |
| Bowel/ Bladder Abnormalities | Yes | No |
| Cancer | Yes | No |
| Dizziness | Yes | No |
| Epilepsy | Yes | No |
| Fracture | Yes | No |
| Hepatitis A, B, C | Yes | No |
| High Blood Pressure | Yes | No |
| Hypoglycemia | Yes | No |
| Immunosuppressant Condition | Yes | No |
| Kidney Problems | Yes | No |
| Liver Problems | Yes | No |
| Metal Implants | Yes | No |
| Pacemaker | Yes | No |
| Pregnancy | Yes | No |
| Ringing in your Ears | Yes | No |
| Skin Abnormalities | Yes | No |
| Smoking | Yes | No |
| Special Diet | Yes | No |
| Other: | | |

***Are you on any medications? Please List:***

|  |
| --- |
| Prescription: |
| Over the Counter: |
| Vitamins: |
| Other: |

**Medical History Form (continued)**

**Use this diagram to indicate the location and type of your pain. Mark the drawing with the following letters in order to best describe your symptoms:**

****

**“A” = aching**

**“B” = burning**

**“N” = numbness**

**“P” = pins and needles**

**“S” = stabbing**

**Rate your discomfort:**

(none) 0 1 2 3 4 5 6 7 8 9 10 (worse)

**Is your current pain:**

Intermittent Constant Radiating

Localized Deep

What position(s) make your pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What position(s) relieves your pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Living Environment** (Please circle)

Do you live alone? Yes No

What type of house do you live in? 1-story house 2-story house Apartment Tri-level Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there stairs within your house or in order to get in to your house? Yes No

If yes, Number of steps: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hand railing present on: Right Left Both None

**Patient, please initial here is the above information is complete and correct: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**



# HEALING STAR PHYSICAL THERAPY AND WELLNESS LLC

Name: DOB:

### CONSENT TO CARE

I wish to be treated by Healing Star Physical Therapy. I am a patient. I permit my therapist and the office employees to treat me using their best judgments and to my benefit. I understand that this care may include and not be limited to: tests, physical examinations, and medical treatments. I understand that no guarantees have been made to me about the outcome of this care.

### FINANCIAL AGREEMENT

I agree to make prompt, complete payments for services rendered to Healing Star Physical Therapy when billed for any and all charges not covered by valid insurance benefits.

**You are responsible to notify us if there are any changes to your insurance**

I understand that failure to do so could result in denial of insurance benefits, and I will be billed for non- covered services.

### CELLULAR PHONE POLICY:

For your safety, and in compliance with the electronic machines used in the physical therapy gym, the use of cell phones is prohibited in the treatment area. You may use your phone for emergency purposes with prior permission. Please remember to keep the phones on silent or vibration mode.

### EMERGENCY SITUATIONS

Please be aware that Healing Star Physical Therapy and Wellness LLC does not have a physician on the premises. It is the practice of Healing Star Physical Therapy to respond to all medical emergencies. If a patient or family member experiences a sudden condition, 911 will be called. If the individual's condition warrants it, he or she will be transported, via ambulance, to the nearest emergency room for further care.

## I HAVE READ THIS FORM, ANY QUESTION HAVE BEEN ANSWERED, AND I UNDERSTAND ITS CONTENTS.

**Patient/Guardian Signature: Date:**

**HEALING STAR PHYSICAL THERAPY AND WELLNESS LLC**

198 Brighton Avenue 145 Wyckoff Rd Suite 102

Long Branch, NJ 07724 Eatontown, NJ 07724

T: (732)-272-1438 T: (848)-208-2721

F: (732)-272-1617 F: (848)-208-2506

I authorize Healing Star Physical Therapy to obtain any and all information from physician(s) for any purpose pertaining to my treatment of care.

Please consider this as an official consent to release the following records to Healing Star Physical Therapy:

* MRI reports
* X-ray reports
* Lab results
* Doctor notes
* Other

I understand that the information disclosed includes my identity diagnosis and treatment. Thank you.

Patient Name: DOB: Patient/Guardian Signature: Date:

Regards,

Meredith Gebel PT, DPT

Philip Joshua MPT, COMT, OCS, SCS Steven George PT, DPT

Varghese Paul MPT, COMT

**Important Company Policies for a Successful Relationship**

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, CHECK ALL THE BOXES, and sign at the bottom that you acknowledge and agree with them.

* **LATE POLICY** - Please inform us if you are going to be late to an appointment. Being more

than 10 minutes late will likely require you to either reschedule or wait for the next available opening.

* **CANCELLATIONS** - if you wish to cancel or reschedule an appointment, we require a

minimum of 24 hours notice. If done in excess, a $50 fee may be charged for cancelled appointments without 24 hour notice.

* **CO-PAYS** are due upon arrival - it is the New Jersey State Law that we collect your co-pay at the time of service
* **NO SHOWS** are highly discouraged. Please make every effort to keep your appointment as our therapist have held that slot specifically for you. Failure to give us proper notice can result in a $50 fee.
* **CELL PHONES** must be put on silent or vibrate only while in therapy. Please do not use your cell phone during your treatment.
* **CHILDREN** requiring supervision are not allowed to attend therapy sessions with you without

permission. We prefer if you schedule your appointments when you can come and relax without interruption.

WE LOOK FORWARD TO BUILDING A SUCCESSFUL RELATIONSHIP WITH YOU THAT LASTS A LIFETIME!

Patient/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_