Dakota County Physical Therapy
Patient Registration

Today's Date____/____/____

PATIENT INFORMATION

Name_____

Address_____

City_____State_____Zip_____

Social Security #_____-_____-_____

Marital Status M S W D

Birthdate_____/_____/_____Age_____

# of Children_____How old?_____

Occupation_____

Employer/School_____

Spouse's Name_____

Birthdate_____/_____/_____Age_____

Spouse's Occupation__

Employer/School_____

CONTACT INFORMATION

Home Phone #(____)_____

Work Phone #(____)_____

Cell Phone #(____)_____

Email_____

MEDICAL INFORMATION

Your Doctor's Name & Clinic Name and City

_____

_____

Doctor's Phone #(____)_____

Whom shall we contact in Case of Emergency?

Name_____

Phone #(____)_____

Purpose of today's visit_____

_____

Days lost from work_____

Date of last Physical Exam_____/_____/_____

Whom shall we thank for referring you today? Or how did you learn about our clinic?

_____

Dakota County Physical Therapy Patient Registration

INSURANCE INFORMATION

Please circle any and all insurance coverage that may be applicable in this case:

Health Insurance	Workers Compensation	Medicaid/MN Care
Medicare	Auto Accident	Other: _____

Name of Primary Insurance Company: _____
Name of Secondary Insurance Company (if any): _____
Name of Auto Insurance (if applicable): _____

I authorize Dakota County Physical Therapy to release medical information to my insurance company.

_____

Patient or Guardian Signature **Date**

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment if my insurance carrier does not pay. I also understand that payment for services is due at the time of service unless other financial arrangements have been made.

_____

Patient or Guardian Signature **Date**

INFORMED CONSENT FOR PHYSICAL THERAPY

A patient, in coming to Dakota County Physical Therapy, gives the doctor permission and authority to care for the patient in accordance with the physical therapy tests, diagnosis and analysis. The physical therapy or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the Doctor of Physical Therapy. The Doctor of Physical Therapy provides a specialized, non-duplicating health care service. Your Doctor of Physical Therapy is licensed in a special practice and is available to work with other types of providers in your health care path to wellness.

I understand that if I am accepted as a patient at Dakota County Physical Therapy, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved regarding physical therapy, will be explained to me upon my request.

_____

Patient or Guardian Signature **Date**

CONSENT OF TREATMENT (MINOR)

I hereby request and authorize Dakota County Physical Therapy to perform diagnostic tests and render physical therapy services to my minor son/daughter _____. This authorization also extends to all other doctors and office staff members at Dakota County Physical Therapy.

_____

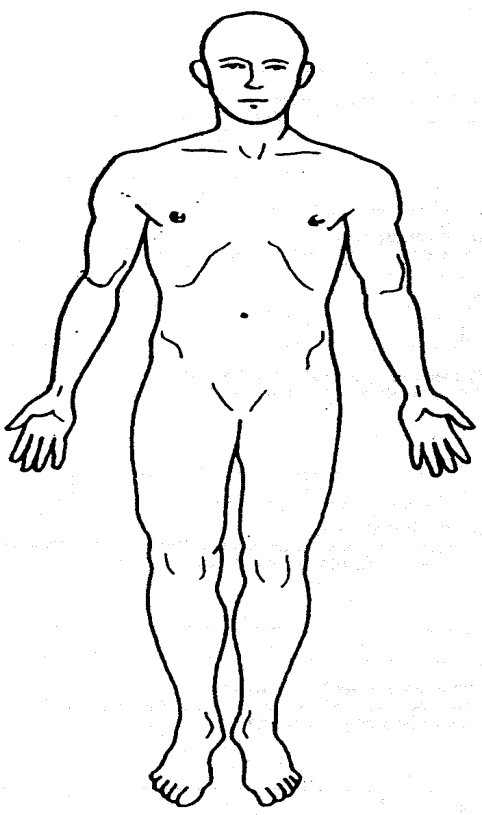
Patient or Guardian Signature **Date**

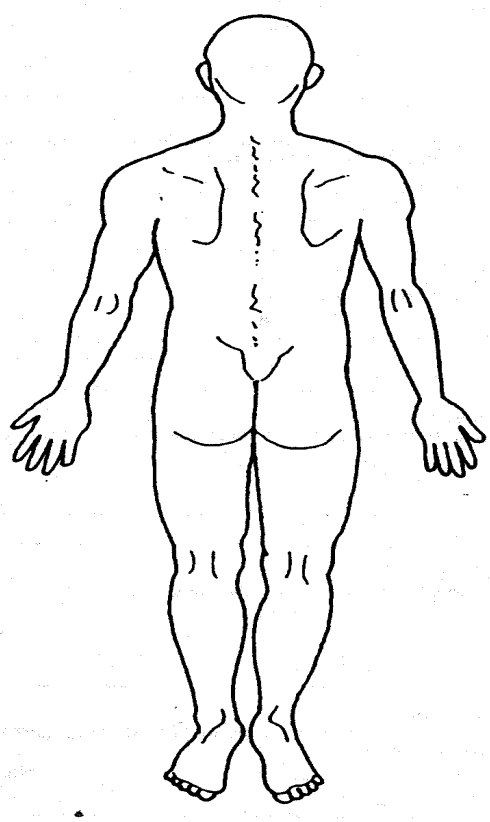
PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Neither

2. Indicate on the drawings below where you have pain/symptoms:





3. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

□ Sharp □ Numb □ Dull □ Tingly □ Diffuse □ Sharp with motion □ Achy
□ Shooting with motion □ Burning □ Stabbing with motion □ Shooting
□ Electric like with motion □ Stiff □ Other:_____

5. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

8. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician □ ER physician
□ Orthopedist □ Therapist □ Physical Therapist □ No one
□ Other:_____

10. How long have you had this problem? _____

11. How do you think your problem began? _____

12. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

13. What aggravates your problem?

_____

14. What alleviates your problem?

_____

15. What concerns you the most about your problem; what does it prevent you from doing?

_____

16. What is your: Height_____ **Weight** _____ **Age** _____
Occupation_____

17. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

18. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

19. List all prescription medications, supplements, and nutrition products you are currently taking:

_____
_____

20. List all of the over-the-counter medications you are currently taking:

_____
_____

21. List all surgical procedures you have had and to what regions:

_____
_____

22. What activities do you do at work?

Sit: □ Most of the day □ Half the day □ A little of the day
Stand: □ Most of the day □ Half the day □ A little of the day
Computer work: □ Most of the day □ Half the day □ A little of the day
On the phone: □ Most of the day □ Half of the day □ A little of the day

23. What activities do you do outside of work?

_____

24. Have you ever been hospitalized? □ No □ Yes If yes, why?

_____

25. Have you had significant past trauma? □ No □ Yes If yes, please describe.

_____

26. Have you been to a physical therapist in the past? If yes, how many treatments did you have and what was the outcome? _____

27. Anything else pertinent to your visit today?_____

_____
_____

28. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure
□	□ Neck Pain	□	□ Heart Attack
□	□ Upper Back Pain	□	□ Chest Pains
□	□ Mid Back Pain	□	□ Stroke
□	□ Low Back Pain	□	□ Angina
□	□ Shoulder Pain	□	□ Kidney Stones
□	□ Elbow/Arm Pain	□	□ Kidney Disorders
□	□ Wrist Pain	□	□ Bladder Infection
□	□ Hand Pain	□	□ Painful Urination
□	□ Hip Pain	□	□ Loss of Bladder Control
□	□ Upper Leg Pain	□	□ Prostate Problems
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss
□	□ Ankle/Foot Pain	□	□ Loss of Appetite
□	□ Jaw Pain	□	□ Abdominal Pain
□	□ Joint Pain/Stiffness	□	□ Ulcer
□	□ Arthritis	□	□ Hepatitis
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder
□	□ Cancer	□	□ General Fatigue
□	□ Tumor	□	□ Muscular In-coordination
□	□ Asthma	□	□ Visual Disturbances
□	□ Chronic Sinusitis	□	□ Frequent Urination
□	□ Dizziness	□	□ Smoking/Tobacco Use
□	□ Diabetes	□	□ Drug/Alcohol Use
□	□ Excessive Thirst	□	□ Allergies
□	□ Depression	□	□ Systemic Lupus
□	□ Epilepsy	□	□ Dermatitis/Eczema/Rash
□	□ HIV/AIDS	□	□ Other:_____

For Females Only

Past	Present
□	□ Birth Control Pills
□	□ Hormone Replacement
□	□ Pregnancy

Family History

Please review the listed diseases and conditions and indicate those that are current health problems for the family member. Please leave blank any conditions that don't apply. If your relative lives in the area, please circle your answers, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age ( )	MOTHER Age ( )	SPOUSE Age ( )	SIBLINGS Age ( ) Age ( )	CHILDREN Age ( ) Age ( )
Arthritis					
Asthma-Hay Fever					
Back Trouble					
Cancer					
Constipation					
Diabetes					
Disc Problem					
Headaches/Migraine					
Heart Trouble					
HighBlood Pressure					
Pinched Nerve					
Scoliosis					
Sinus Trouble					
Stomach Trouble					
Other:					

If any of the above family members are deceased, please list their ages at death and the cause:

_____

_____

I certify that the information provided is accurate to the best of my knowledge.

Name:_____

Signature:_____

Date:_____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care treatments we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care. I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.
8. I understand that upon entering this clinic, my name will be signed on a sign-in sheet that will remain in the reception area of the clinic. I also realize that any person entering this office may read my name on the sign-in sheet as a patient.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____

Patient or Guardian Signature **Date**

MASSAGE THERAPY CANCELLATION POLICY

If you need to cancel your massage appointment, please contact our office at least 24 hours in advance. We understand emergencies occur, but in consideration of our schedule and other patients, please provide a 24-hour notice when cancelling massages. You have the option to either call our office during business hours or during after business hours notify the office by email- contact@dakotacountypt.com If proper notice is not given, you will be charged a $40 cancellation fee.

Signature_____Date_____