IDAHO MOBILE PHYSICAL THERAPY

PATIENT REGISTRATION FORM Date: _____

Patient Information

First Name:	MI:	Last Name:
Address:	City:	State/Zip:
Date of birth:	Age:	Gender: M F
Cell:	Home:	Email:
How would you like to receive appointment reminders? (Please Circle) Cell Call Cell Text Email		

Emergency Contact Information

First Name:	Last Name:	Relation:
Cell:	Home:	Email:

Parent/Guardian Information (If patient is a minor)

First Name:	Last Name:	Relation:
Address:	City:	State/Zip:
Cell:	Home:	Email:

Injury/Condition Information:

Condition:		Date of onset:
Was this an injury? YES NO	Injury area (If applicable):	
Type of injury (please circle): Sport Work Accident Illness N/A Other:		
Was this an auto accident? YES NO	A work accident? YES NO	If so, is there litigation involved? YES NO
What are your personal goals/outcomes you wish to achieve from physical therapy?		

How did you hear about us? (Please Circle)

Friend/Former Patient Physician Marketing Ad Internet Search Facebook Instagram Other: ____

I certify that all the information provided herein is true and correct.

_____	_____	_____
Patient/guardian name (Print)	Patient/guardian signature	Date:
_____	_____	_____
Witness name (Print)	Witness signature	Date:

IDAHO MOBILE PHYSICAL THERAPY

HEALTH HISTORY QUESTIONNAIRE Date: _____

Welcome to Idaho Mobile Physical Therapy! Please take a few minutes to let us know how we can help you. This will allow us to develop a treatment plan to meet your personal needs. If you have any questions as to how to complete this form, please leave that section blank and ask the therapist for help. Thank you and we look forward to serving you.

PAIN SCALE
(1-10) 0= None 5= Moderate 10= Extreme
Current: _____
Best: _____
Worst: _____

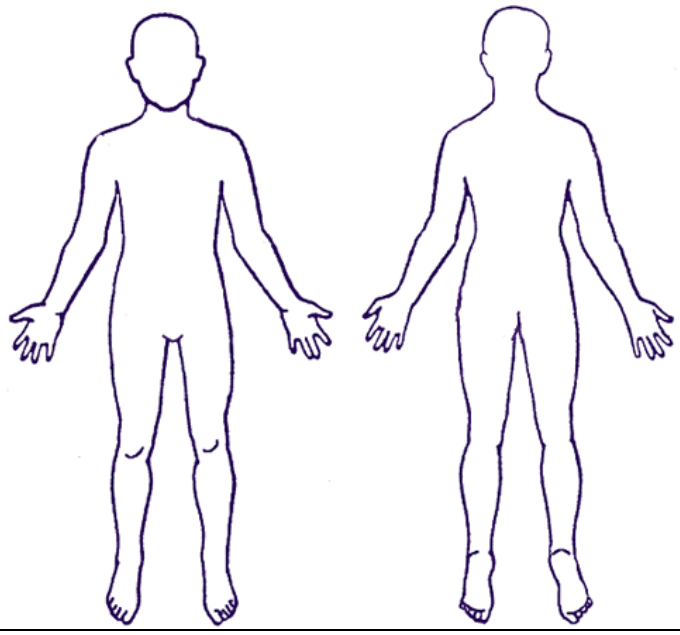
AGGRAVATING FACTORS
(Activities that increase your pain)

DESCRIPTION OF PAIN

☐ Burning ☐ Numbness ☐ Tingling
☐ Constant ☐ Sharp ☐ Worse at Night
☐ Dull/Achy ☐ Shooting ☐ Worse in Morning
☐ Intermittent ☐ Throbbing
☐ Other:

EASING FACTORS
(Things that decrease your pain)

On the diagram below, please shade in the area of your body where you have pain, numbness, and/or tingling. Describe the pain (i.e. burning, aching, sharp, dull) next to the shaded area.



GENERAL HEALTH STATUS

☐ Excellent
☐ Good
☐ Fair
☐ Poor
☐ Other:

CURRENT ACTIVITY LEVEL

☐ Sedentary
☐ Light
☐ Medium
☐ Heavy
☐ Other:

I certify that all the information provided herein is true and correct.

_____ _____ _____
Patient/guardian name (Print) Patient/guardian signature Date:

_____ _____ _____
Witness name (Print) Witness signature Date:

IDAHO MOBILE PHYSICAL THERAPY

HEALTH HISTORY QUESTIONNAIRE CONT'D

TREATMENTS RELATED TO CONDITION

- ☐ Acupuncture
- ☐ Chiropractor
- ☐ Family Practitioner
- ☐ Massage Therapist
- ☐ Other: _____ _____
- ☐ Occupational Therapist
- ☐ Orthopedist
- ☐ Osteopath
- ☐ Pediatrician
- ☐ Podiatrist
- ☐ Primary Care Physician

DIAGNOSTIC TESTS

- ☐ Arthroscopy
- ☐ Blood Tests
- ☐ Bone Scan
- ☐ Bronchoscopy
- ☐ CT Scan
- ☐ Doppler Ultrasound
- ☐ EMG
- ☐ Other: _____ _____
- ☐ MRI
- ☐ Myelogram
- ☐ NCV
- ☐ Pulmonary Function Test
- ☐ Stress Test
- ☐ X-Rays

FUNCTIONAL LIMITATIONS

- ☐ ADLs
- ☐ Ambulation/Mobility
- ☐ Bending
- ☐ Community Activities
- ☐ Lifting/Carrying
- ☐ Pulling
- ☐ Pushing
- ☐ Stairs
- ☐ Other: _____ _____
- ☐ Reaching
- ☐ Self-Care
- ☐ Sitting
- ☐ Sleeping
- ☐ Sports
- ☐ Squatting
- ☐ Standing
- ☐ Recreational Activities
- ☐ Work

MEDICAL/SURGICAL HISTORY

- ☐ Allergies
- ☐ Arthritis
- ☐ Blood Disorders
- ☐ Broken Bones
- ☐ Cancer
- ☐ Cardiovascular Disease
- ☐ Circulation / Vascular
- ☐ Diabetes
- ☐ *Denies PMH
- ☐ Depression
- ☐ Developmental Problems
- ☐ Head Injury
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Infectious Disease
- ☐ Other: _____ _____
- ☐ Kidney Problems
- ☐ Lung Problems
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Psycho-Social
- ☐ Repeated Infections
- ☐ Seizures/Epilepsy
- ☐ Skin Disease
- ☐ Stroke
- ☐ Surgeries
- ☐ Thyroid Problems
- ☐ Ulcers/Stomach Problems

MEDICAL SYMPTOMS (PAST YEAR)

- ☐ Bowel Problems
- ☐ Chest Pains
- ☐ Coordination Problems
- ☐ Cough
- ☐ Difficulty Sleeping
- ☐ Difficulty Swallowing
- ☐ Difficulty Walking
- ☐ Dizziness/Blackouts
- ☐ Fever/Chills/Sweata
- ☐ Hearing Problems
- ☐ Heart Palpitations
- ☐ Other: _____ _____
- ☐ Hoarseness
- ☐ Joint Pain or Swelling
- ☐ Loss of Appetite
- ☐ Loss of Balance
- ☐ Nausea/Vomiting
- ☐ Pain at Night
- ☐ Pregnancy
- ☐ Shortness of Breath
- ☐ Urinary Problems
- ☐ Vision Problems
- ☐ Weak Arms or Legs
- ☐ Weight Loss/Gain

CURRENT MEDICATION

- ☐ Advil
- ☐ Aleve
- ☐ Aspirin
- ☐ Cortisone Injection
- ☐ Decongestants
- ☐ Other: _____ _____
- ☐ Dietary Supplements
- ☐ Herbal Supplements
- ☐ Ibuprofen
- ☐ Naproxen
- ☐ Tylenol

IDAHO MOBILE PHYSICAL THERAPY

HEALTH HISTORY QUESTIONNAIRE CONT'D

Please list all surgeries, and the year they occurred.

Are you currently experiencing any flu-like symptoms? (i.e. fever, coughing, etc.) YES NO
If yes, what symptoms?

I certify that all the information provided herein is true and correct.

_____	_____	_____
Patient/guardian name (Print)	Patient/guardian signature	Date:
_____	_____	_____
Witness name (Print)	Witness signature	Date:

IDAHO MOBILE PHYSICAL THERAPY

SOCIAL/HEALTH HABITS Date: _____

SMOKING

☐ Does NOT currently smoke tobacco

☐ DOES currently smoke tobacco

How many packs per day? _____

How many cigars/pipes per day? _____

☐ Smoked in the past Year quit: _____

ALCOHOL

Do you ever drink alcohol? YES NO

If yes, how many days per week to you drink, on average? _____

How many drinks do you have on an average day? _____

EXERCISE

Do you exercise beyond daily activities and chores? YES NO

Describe the exercise: _____

_____

On average, how many days per week do you exercise? _____

SOCIAL STATUS

☐ Single
☐ Married
☐ Divorced
☐ Lives Alone
☐ Lives with Family
☐ Lives with Roommate
☐ Widow/er
☐ Other:

Occupation: _____

Physical requirements of your work: _____

Sports and fitness activities: _____

Which is your dominant side? RIGHT LEFT

Do you use recreational drugs? YES NO

IDAHO MOBILE PHYSICAL THERAPY

SOCIAL/HEALTH HABITS CONT'D

Do you smoke, Vape, or chew tobacco? YES NO

Are you allergic to latex, or tape? YES NO

Please list all other allergies: _____

I certify that all the information provided herein is true and correct.

_____	_____	_____
Patient/guardian name (Print)	Patient/guardian signature	Date:
_____	_____	_____
Witness name (Print)	Witness signature	Date:

IDAHO MOBILE PHYSICAL THERAPY

CONSENT TO TREATMENT

I consent to be treated by Jason LaBarthe, PT, MPT, OCS, and Idaho Mobile Physical Therapy for the injury/illness for which I have consulted. In doing so, I voluntarily consent to the rendering of such care within the physical therapist scope of practice. Initials: _____

I understand, acknowledge and affirm that such a rehabilitation and related services may involve body contact, touch and/or direct contact of a sensitive nature. Initials: _____

I acknowledge that no guarantees have been made to me as to the results of examination or treatment by Jason LaBarthe, PT, MPT, OCS and Idaho Mobile Physical Therapy. Initials:_____

I understand and agree that Jason LaBarthe, PT, MPT, OCS and Idaho Mobile Physical Therapy provides in-home physical therapy treatment for my convenience. I hereby consent to allow Jason LaBarthe and Idaho Mobile Physical Therapy to come into my home to provide such physical therapy services. Initials: _____

Treatment of Minors
I, as a parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I, or my spouse are required to remain on the premises during any such treatment. Initials: _____

Females Only
I do hereby agree and understand that at least one other adult is required to remain on the premises during any such treatment. Initials: _____

Liability
I understand and agree that Jason LaBarthe, PT, MPT, OCS, and Idaho Mobile Physical Therapy are not responsible for loss or damage to personal valuables. Initials:_____

Waiver and Release
I hereby release, discharge and acquit Idaho Mobile Physical Therapy, its agents, representatives, affiliates, employees, from any and all liability, claim, demand, damage, cause of action or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, emergency medical technician, physician or urgent care services. Initials: _____

Release of Information
I authorize Idaho Mobile Physical Therapy to communicate directly regarding my care with my other health care providers, my insurance company, and the following individuals/organizations I have listed below. A complete copy of HIPAA compliance guidelines is available on request. Initials: _____

_____

_____

I acknowledge I have received a copy of the notice of privacy practices. Initials: _____

_____	_____	_____
Patient/guardian name (Print)	Patient/guardian signature	Date:
_____	_____	_____
Witness name (Print)	Witness signature	Date:

IDAHO MOBILE PHYSICAL THERAPY

FINANCIAL POLICY

I understand and agree I am financially responsible for the full payment for the services I receive. Initials: _____

I understand and agree that payment is due in full at the time services are rendered. Initials: _____

I understand and agree that the only accepted forms of payment are cash, check, debit card, or credit card. Initials: _____

I understand and agree that Idaho Mobile Physical Therapy will not attempt to bill my insurance company for services I receive. Initials: _____

I understand and agree that I will receive a receipt and/or superbill within 24 hours of my treatments, and it is my responsibility to seek reimbursement from my insurance company if able. Initials: _____

I understand and agree that Idaho Mobile Physical Therapy does not guarantee I will receive any reimbursement from my insurance company, even if I submit a receipt and/or superbill provided by T3 Physical Therapy. Initials: _____

I understand and agree Idaho Mobile Physical Therapy does not accept auto accident liens. Initials: _____

MISSED APPOINTMENTS

Broken appointments or late notice cancellations are a significant cost to Idaho Mobile Physical Therapy. Cancellations are required at least 24 hours prior to the scheduled appointment, to give Idaho Mobile Physical Therapy adequate time to offer the timeslot to another patient. I agree and understand that Idaho Mobile Physical Therapy reserves the right to charge $50 for missed appointments. Exceptions may be made in certain extenuating circumstances including but not limited to a first-time broken appointment or late notice cancellation due to illness or family emergency. Initials: _____

_____	_____	_____
Patient/guardian name (Print)	Patient/guardian signature	Date:
_____	_____	_____
Witness name (Print)	Witness signature	Date:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Idaho Mobile Physical Therapy is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care in the event of an emergency.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings
We may disclose your health information in the course of any administrative or judicial proceeding.

Public Safety
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Change of Ownership
In the event that Idaho Mobile Physical Therapy, LLC is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights
You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Idaho Mobile Physical Therapy is not required to agree to the restriction that you requested.

IDAHO MOBILE PHYSICAL THERAPY

NOTICE OF PRIVACY PRACTICES CONT'D

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request

You have the right to inspect and copy your health information.

You have a right to request that Idaho Mobile Physical Therapy amend your protected health information. Please be advised, however, that Idaho Mobile Physical Therapy is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by Idaho Mobile Physical Therapy.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Idaho Mobile Physical Therapy with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print) _____

Signature _____

Date _____

IDAHO MOBILE PHYSICAL THERAPY

TEXT AND EMAIL DISCLAIMERS

May we send you text reminders for your appointment reminders to the cell phone number you have provided? By marking "Yes" below you acknowledge that you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

□ Yes □ No Initials: _____

May we send you text messages the day after physical therapy sessions to inquire about the status of your symptoms and to determine how your symptoms responded to the previous day's treatment? By marking "Yes" below you acknowledge that you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

□ Yes □ No Initials: _____

May we send you emails relating to your care with us? By marking "Yes" below you acknowledge that you understand that email messages may NOT be secure, with a risk of unauthorized access to your information.

□ Yes □ No Initials: _____

May we send you emails including your evaluation report, superbills for each session, progress notes, and discharge summary? These documents will contain personal information including your name, date of birth, and physical therapy diagnoses. By marking "Yes" below you acknowledge that you understand that email messages may NOT be secure, with a risk of unauthorized access to your information.

□ Yes □ No Initials: _____

Superbills require your social security number, address, policy carrier, and policy number. It is the policy of Idaho Mobile Physical Therapy that we will not fill in that information for personal information security reasons. By marking "Yes" below you acknowledge that you understand you will need to fill out that information on your own before submitting to your insurance company for reimbursement.

□ Yes □ No Initials: _____

_____	_____	_____
Patient/guardian name (Print)	Patient/guardian signature	Date: