MEDICAL HISTORY/REGISTRATION FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

Email Address:_____

Phone #_____

Mobile #_____

Address City State Zip

Chief Compliant:

Have you had any prior (Hospital, Home or Out- Patient Clinic) physical therapy services for this injury?

Referring Physician:

Physician's Office Number:

Physician's Office Fax Number:

Occupation:

Employer: Work #_____

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Blood Clots	❑ Arthritis	❑ Dizziness/Fainting
❑ Diabetes	❑ Heart murmur	❑ Crohn's disease
❑ High blood pressure	❑ Pneumonia	❑ Colitis
❑ High cholesterol	❑ Pulmonary embolism	❑ Anemia
❑ Hypothyroidism	❑ Asthma	❑ Jaundice
❑ Goiter	❑ Emphysema	❑ Hepatitis
❑ Cancer (type) _____	❑ Stroke/TIA	❑ Stomach or peptic ulcer
❑ Leukemia	❑ Epilepsy (seizures)	❑ Rheumatic fever
❑ Psoriasis	❑ Cataracts	❑ Tuberculosis
❑ Angina	❑ Kidney disease	❑ HIV/AIDS
❑ Heart problems	❑ Kidney stones	❑ Allergies_____
❑ Smoking Daily___ Weekly____	❑ Sleep Difficulties	❑ Vision Difficulties
❑ Alcohol Consumption Daily__ Weekly__		

Other medical conditions (please list):

LIST SURGERIES:

Height_____ **Weight** _____

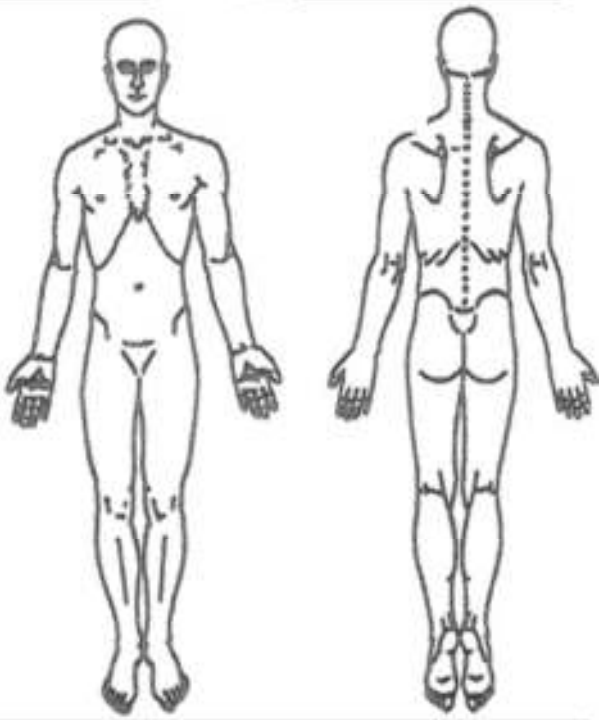
Pain and Symptom Status Report

Name: _____ Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM	— — —	0 0 0 0
M	— —	0 0 0

Pins and Needles	Stabbing	Other
o o o o o o o o o	/ / / / / /	x x x x
o o o o o o o o	/ / / /	x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on. _____

2nd Complaint _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your <u>WORST</u> level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Additional Comments _____

Emergency Contact:

Name: _____ Phone Number: _____

CURRENT MEDICATIONS	
Drug allergies: ❑ No ❑ Yes To what? Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:	
Name of drug	**Dose (include strength & number of pills per day)**
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	

FIRST INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

SECOND INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

THIRD INSURANCE INFORMATION

Plan Name: _____ I.D. Number: _____
Address: _____ Group Number: _____
Policy Holder: _____ Effective Date: _____
Policy Holder's Social Security Number: _____ - _____ - _____
Policy Holder's Date of Birth: _____/_____/_____ Sex: M / F

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT?
Y _____ N_____
IF YES, PLEASE NOTIFY THE RECEPTIONIST

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Atlanta Human Performance Center. I acknowledge that I am financially responsible for payment whether or not covered by insurance.
Signature: _____ Date: _____

3250 Hogan Road, SW
Atlanta, Georgia 30331
(404) 346-1526 Office
(404) 346-0729 Fax

MEDICATION DOCUMENTATION		
Patient Name:	**Allergies**	
NAME OF MEDICATION	**DOSAGE**	**FREQUENCY**

3250 Hogan Road, SW Atlanta, Georgia 30331
(404) 346-1526 office / (404) 346-0729 Fax

Atlanta Human Performance Center is a healthcare provider and will share my health information for treatment, payment and healthcare operations, including to my referring physician. I have been provided access to the Notice of Privacy Practices that describes how my health information is used and shared. I also have access to a copy of these rights to retain for my records. I understand that Atlanta Human Performance Center has the right to change this notice at any time. I may obtain a current copy by contacting the Privacy Officer at (404) 346-1526.

My signature below constitutes my acknowledgement that I have been provided access to the Notice of Privacy Practices.

If any person is physically unable to provide a signature or signs with a mark, print his/her name on the appropriate line below and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgement.

If patient is not capable of acknowledging the notice because of age or medical condition, complete the following:

Patient is a minor (_____ years of age) or Patient *is* unable to acknowledge because of medical condition.

_____/_____/_____
PATIENT/LEGAL GUARDIAN/RELATIVE SIGNATURE DATE LEGAL GUARDIAN/RELATIVE RELATIONSHIP

_____/___/___ _____/_____/___
WITNESS DATE WITNESS DATE

☐ I authorize ***Atlanta Human Performance Center*** to leave a message on my answering machine/voice mail regarding my appointments or results information.

☐ I authorize ***Atlanta Human Performance Center*** to include the following person(s) in any conversations regarding my Protected Health Information:

_____
NAME RELATIONSHIP

_____
NAME RELATIONSHIP

_____
NAME RELATIONSHIP

_____ ___/___/___
PATIENT SIGNATURE **DATE**

PATIENT MISSED APPOINTMENT POLICY

It is very important that you report to the clinic ***on time*** for your appointments. Your adherence to the recommended number of treatments is a vital component to your progress with our service; therefore, we expect you to keep ALL your physical therapy appointments, with the exception of emergencies.

If are unable to make your appointment and you need to reschedule an appointment we **require a 24 hour notification.** Please call our office and arrange to reschedule your cancelled appointment. Cancelled appointments must be in the same week.

Please contact the clinic immediately to cancel and/or reschedule your appointment. A cancelled appointment can be used for another patient.

A missed appointment means a lost opportunity for another patient who may need that appointment time.

In an instance of a cancellation without a **24 hours notification**, AHPC will charge your account a **$50.00 no show fee**. **No Show Fees are your responsibility and are not covered by your Health Insurance.**

I ACKNOWLEDGE I HAVE READ THE ABOVE ON STATED POLICY

Signature of acknowledgement: _____ Date: _____

CELL PHONE USE

ALL patients are required to turn their cell phones on vibrate prior to entering the building. Use of mobile devices is only allowed in an emergency.

We also request that you **NEVER use your mobile device at the Front Desk or Treatment Room**. Failure to comply will result in delay of your treatment.

I ACKNOWLEDGE I HAVE READ THE ABOVE STATED POLICY

Signature of acknowledgement: _____ Date: _____