Performance Therapy Group

PATIENT REGISTRATION FORM

Please skip the box below if we can copy your most current/accurate TX driver's license.

Last Name: __________________________ First Name: __________________ Middle Initial: _____

Address: ____ City: ___________ State: ____ Zip: _______

Patient Birth Date: ___________________ Driver's License #: _____________________ Birth Sex: M / F

Patient Home/Mobile Phone #:(______)_______-_________ We use a mobile text-based reminder system.

May we email you: Specials/Updates yes/no; **Treatment Plan** yes/no; E-mail: ______________________________

Patient Employer/Occupation or School/Sport: ____

Primary Doc/Pediatrician (Full name & contact) : ____

Check this box ☐ if you do NOT want us to send your doctor progress notes regarding your care.

Emergency Contact/Partner Name & Phone #: ____

How did you hear about us? Who/Where? ____

PAYMENT INFORMATION

Would you like us to bill your insurance company for their portion of your care? ☐ Yes ☐ No

If someone else is responsible for your bill, complete the following information (if different from above):

Guarantor's Name: ______________________________ Mobile Phone #:(______)_______-________

Address: ____ City: ___________ State: ____ Zip: _______

Employer: ________________________________ Work Ph # (_____)________________________

Guarantor SS#: _____________________________ Guarantor DOB: _______________________

Patient's Relationship to Guarantor:____

AUTHORIZATION, FINANCIAL RESPONSIBILITY, AND CONSENT TO TREAT

I authorize Performance Therapy Group (PTG) and its employees to release or obtain my medical information to any insurance company, attorney, insurance adjuster, employer or their representative as may be necessary in the treatment and payment of my care.

I understand and authorize that

- payment is due in full at the time of services unless special payment arrangements are made.
- there will be a **$30.00 service charge on all returned checks**.
- I will be responsible for **50% of the cost of the visit for failure to keep any scheduled appointment** without 24 hours prior notification.
- if my health insurance is not contracted with PTG, then I assign my health insurance benefit, my personal injury protection benefit, and my medical payment benefit to PTG as needed to pay my bill for services rendered and **such payment should be made directly to "Performance Therapy Group"**.

I consent to all necessary examination procedures and/or treatments prescribed by my chiropractor, his/her assistants, or designees as is necessary in his/her judgment.

X ____ ____________________

Patient (or Guardian) Signature **Date**

PERFORMANCE THERAPY GROUP

PATIENT HISTORY FORM 1 – CURRENT PROBLEM

Patient Name: ______________________________ **Patient DOB:** _________ **Date:** __________

IF YOU HAVE MORE THAN ONE COMPLAINT, PRINT & COMPLETE THIS PAGE FOR EACH PROBLEM

Current Problem: ____________________________________

____

History of Current Problem:

When did your most recent problem begin? ________________

How did it begin?

- ☐ Immediately after a specific event ☐ Multiple events
- ☐ Gradually developed ☐ No apparent reason

What do you think is causing your problem?:________________

____

Is your pain ☐ constant ☐ intermittent ☐ only w/ movement

Is your pain ☐ improving ☐ worsening ☐ not changed

Have you had this problem before? ☐ Yes ☐ No When? ________

What makes your problem better? ______________________

____

What makes your problem worse? ______________________

____

Rate your pain level: **now** ____/10 **At its worst** ____/10

No pain 0 1 2 3 4 5 6 7 8 9 10 Most intense pain imaginable

Is there anything else you feel might be related to this problem?

____

Prior tests: X-ray, MRI, CT, ultrasound, lab, other:__________

____

Prior treatment for your current problem?

- ☐ None ☐ Physical therapy ☐ Chiropractic ☐ Acupuncture
- ☐ Massage ☐ Injections ☐ Surgery ________________
- ☐ Medications (frequency/dosage) ________________
- ☐ Other ________________________________

What have you been told is wrong? ______________________

When was treatment and did it work? ______________________

FOR PROVIDER USE

_____yo_______________♀♂__________

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TODAY?__________________________

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WC/MVA__________________________

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worse_w/_sitting/lifting/morning/____

valsalva/standing/walking/____________

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GOALS:__________________________

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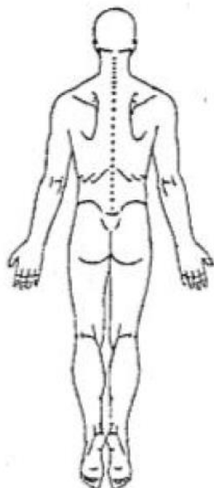
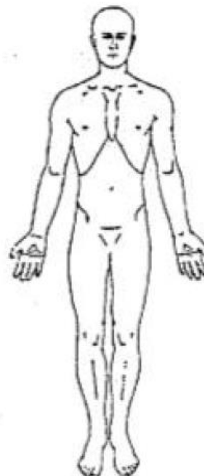
CONCERNS:________________________

Fill out the pain drawing below using the following symbols:

XXXXX Sharp ***** Dull ☐☐☐☐☐ Numbness 00000 Pins & Needles

DDX

CA__________

Fx(stress)_____

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PERFORMANCE THERAPY GROUP

PATIENT HISTORY FORM 2 – RELATED HISTORY

Patient Name: ______________________________ Patient DOB: _________ Date: __________

Family Medical History: ☐ Rheumatoid arthritis ☐ Heart disease
☐ Diabetes ☐ Arthritis ☐ Muscle disease ☐ Scoliosis ☐ Hypertension
☐ Cancer ☐ Drug allergies ☐ Abnormal bleeding ☐ Other ________
Living parents? Mother ☐ Yes ☐ No; Deceased at age ___of _______
Father ☐ Yes ☐ No; Deceased at age ___of _______

Current Work Status: Time at Position: _____________________

	Sitting	Standing	Walking	Driving	Lifting*
Total Hours					

* If lifting at work, what is the average weight? ___ lbs. How often?______

List of all supplements and medications you are currently taking:
____
____

Lifestyle Habits: ☐ Tobacco ____ (# cigs/day) Years smoked _____
Hobbies: ____
Please rate the quality of your diet: poor/fair/good/great/exceptional
How often do you: eat out? ____/wk fast food ___/day/wk
Caffeine beverages _____(#/day) Alcohol (#drinks/day) __________
Avg. fluid intake/day ______ What form? Water?________________
Avg. hrs sleep/night: ____ Do you feel rested? ______
Currently exercising? ☐ Yes ☐ No; last regular exercise ________
Weekly exercise activities, volume & intensity→
Rate current stress level: ☐ none ☐ minimal ☐ moderate ☐ high
What causes you stress? ___________________________________

Past Medical History:
☐ Cancer ☐ Arthritis ☐ Alcoholism ☐ Kidney disease
☐ Diabetes ☐ Seizures ☐ Lung Disease ☐ Thyroid Disease
☐ Ulcers ☐ Glaucoma ☐ Heart Disease ☐ Tuberculosis
☐ AIDS/HIV ☐ Hepatitis ☐ Diverticulitis ☐ High Blood Pressure
☐ Stroke ☐ Anemia ☐ Pacemaker ☐ Blood Thinners
☐ Joint Replacement ☐ Depression ☐ Anxiety ☐ Other__________

Surgeries/Hospitalizations
Yr ___ ________________
Yr ___ ________________
Yr ___ ________________
Yr ___ ________________

Injuries/Fractures/Dislocations
Yr ___ ____________________
Yr ___ ____________________
Yr ___ ____________________
Yr ___ ____________________

Review of Symptoms: (please check all that apply)
☐ Fever ☐ Fatigue ☐ Unexplained weight loss
☐ Night sweats ☐ Sore throat ☐ Abrupt change in vision
☐ Chest pain ☐ Cough ☐ Abrupt change in hearing
☐ Nausea ☐ Vomiting ☐ Difficulty swallowing
☐ Bleeding ☐ Diarrhea ☐ Difficulty breathing
☐ Poor circulation ☐ Rash ☐ Pain/swollen joints
☐ Dizziness ☐ Numbness ☐ Muscle weakness
☐ Hot flashes ☐ Bruise easily ☐ Allergies to pollen etc.
☐ Burning on urination ☐ Immune system dysfunction
☐ Loss of bowel/bladder control ☐ Infection
☐ Difficulty sleeping ☐ Depression ☐ Anxiety

FOR PROVIDER USE
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Weekly exercise log
M____________________________
Tu___________________________
W____________________________
Th___________________________
F____________________________
Sat__________________________
Sun__________________________

FOR PROVIDER USE
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PERFORMANCE THERAPY GROUP

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPTIONS

Patient Name: ______________________________ Patient DOB: _________ Date: __________

I consent to the use or disclosure of my protected health information by Performance Therapy Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Performance Therapy Group. I understand that diagnosis or treatment of me by any and or all of the providers at Performance Therapy Group may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice is not required to agree to the restrictions that I may request. However, if Performance Therapy Group agrees to a restriction that I request, the restriction is binding on Performance Therapy Group and its providers.

I have the right to revoke this consent, in writing, at any time, except to the extent that the treating provider or Performance Therapy Group has taken action in reliance on this consent. My "protected health information" means health information, including my demographic information, collected from me and created or received by my provider, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand that during the course of daily healthcare operations, my “protected health information” may be indirectly disclosed to a third party who overhears a discussion regarding your information. I understand and agree that this is not a breach of my “protected health information.” I understand I have a right to review Performance Therapy Group’s Notice of Privacy Practices prior to signing this document. Performance Therapy Group’s Privacy Practices have been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Performance Therapy Group. The Notice of Privacy Practices is also posted in the lobby of all clinics. This Notice of Privacy Practices also describes my rights and Performance Therapy Group’s duties with respect to my protected health information. Performance Therapy Group reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made or any decisions we may make regarding the use, disclosure, or access to your health information you may complain to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please direct any of your questions or complaints to:

Contact: Dr. Ross Bomben or Debbie Thurmond
Phone: (512) 330-9965

_______________________________________ _______________
Signature of Patient or Personal Representative Date

____
Name of Patient or Personal Representative