"We look forward to the opportunity to serve you."

SOUTHERN PHYSICAL THERAPY CLINIC

1620 Hwy 11 N Suite C
Picayune, MS 39466
P: 769-242-2626
F: 769-242-2685

Patient Registration

Date:	First Name, Middle Initial:	Last Name:
Date of Birth:	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Employer:	Occupation:	
Referring Physician (*first, last*):	Primary Care Physician (*first, last*):	How did you hear about us?
Present / Primary Complaint:	How long has this been bothering you?	

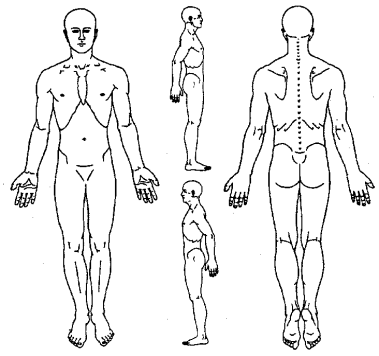
How did this condition occur? Please check all that apply:

☐ Accident ☐ Fall ☐ Gradually ☐ Work Injury ☐ Lifting ☐ Sport ☐ Surgery ☐ Other _____

Are you experiencing pain or abnormal sensations??
☐ Yes ☐ No

Rate (0 none – 10 worst imaginable) Currently: _____ At Best: _____ At Worst: _____

Please indicate the location of pain / sensation with an "X"



What positions or activities makes your symptoms worse?

☐ Sitting ☐ Standing / Walking ☐ Increased Activity
☐ Lifting ☐ Pushing ☐ Pulling
☐ Other: _____

What positions or activities make your symptoms better?

☐ Sitting ☐ Standing / Walking ☐ Laying down / Rest
☐ Medication ☐ Ice ☐ Heat
☐ Other: _____

What tests have been done for this condition? (check all that apply)

☐ CT Scan ☐ MRI ☐ X Ray ☐ EMG ☐ Bone Scan
☐ Ultrasound ☐ None ☐ Other _____

Have you had PT or OT before?
(Either for this condition or a different one)
☐ Yes ☐ No

Have you or are you receiving any other medical treatments for this condition?

What are your top 2-3 passions or hobbies?

1.

2.

3.

What needs to happen for this to be a successful experience for you?

"We look forward to the opportunity to serve you."

SOUTHERN PHYSICAL THERAPY CLINIC

1620 Hwy 11 N Suite C
Picayune, MS 39466
P: 769-242-2626
F: 769-242-2685

Health Status Form

How would you best describe your overall general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please Explain: _____

Are there any areas within your current health habits that you would be interested in seeking additional support?
(*Check All That Apply*) ☐ Diet / Nutrition ☐ Physical / Fitness ☐ Mental /Emotional ☐ Medical ☐ None

Please Explain: _____

Past Medical History

If yes, please provide details

High Cholesterol	☐ Yes	☐ No	_____	Stroke	☐ Yes	☐ No	_____
High Blood Pressure	☐ Yes	☐ No	_____	Blood Clots	☐ Yes	☐ No	_____
Heart Problems	☐ Yes	☐ No	_____	Pacemaker	☐ Yes	☐ No	_____
Seizures/Neurological	☐ Yes	☐ No	_____	Cancer/Tumor	☐ Yes	☐ No	_____
Behavioral/Learning	☐ Yes	☐ No	_____	Diabetes	☐ Yes	☐ No	_____
Anxiety/Depression	☐ Yes	☐ No	_____	Hepatitis/HIV	☐ Yes	☐ No	_____
Genetic/Congenital	☐ Yes	☐ No	_____	Asthma/COPD	☐ Yes	☐ No	_____
Are you pregnant?	☐ Yes	☐ No	_____	Do You Smoke?	☐ Yes	☐ No	_____
Bone Joint Problems	☐ Yes	☐ No	_____	If so, how much:			_____

Other (describe): _____

Significant Past Surgeries: _____

Medications/Allergies

List all medications (prescription & OTC medication/vitamins) or attach list, include dosage and method: _____

_____

_____

List all food and medical allergies (include latex & adhesives): _____

_____

_____

Daily Activities

What does your job and/or home duties require? Check all that apply:

☐ Computer Work	☐ Standing	☐ Reaching	☐ Carrying
☐ Kneeling/Squatting	☐ Walking	☐ Climbing	☐ Lifting
☐ Repetitive Movement/Twisting	☐ Writing	☐ Pushing/Pulling	☐ Other _____

_____ _____

Signature of Patient or Legally Authorized Representative Date

"We look forward to the opportunity to serve you."

1620 Hwy 11 N Suite C
Picayune, MS 39466
P: 769-242-2626
F: 769-242-2685

Please initial and date where indicated below:

Consent to Treatment

I hereby authorize the profession staff at **Southern Physical Therapy** to examine and treat me with physical therapy and/or occupational therapy for the Injury and/or Condition that I have been referred here for or referred myself to.

_____ _____
Patient / Caregiver Initial **Date**

HIPAA Regulations

I understand that **Southern Physical Therapy** complies with HIPAA and will protect my Protected Health Information (PHI). I understand my information will be used as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to my insurance company, adjuster, attorney, or medical provider for purpose of securing payment. This authorization remains in effect until 90 days from the date of last bill collected.

_____ _____
Patient / Caregiver Initial **Date**

Assignment and Instruction for Direct Payment to Health Provider

Insurance Company/Companies(S) _____

I hereby instruct the above-named insurance company/companies to pay by check made out to and mailed directly to **Southern Physical Therapy** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy. This is a direct assignment of my rights and benefits under this policy**.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

_____ _____
Patient / Caregiver Initial **Date**