InMotion PHYSICAL THERAPY

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Patient Registration Form

Please print all responses

Name		Sex		Age		Birth Date	/ /
Address		City				Zip Code	
Home Phone #		Cell Phone #		Email Address			
Emergency Contact		Relationship to You		Phone #			
What is your employment status?	☐ Working	☐ Retired	☐ Unemployed	☐ Disability *(Temp or Perm)*			
What is your occupation?		☐ Full Time	☐ Part Time				

REFERRAL INFORMATION

Who referred you to our office?	☐ My Doctor	☐ Family / Friend	☐ Other (*Please specify*)
Name		Cell Phone #	

GENERAL INQUIRY

Have you had home health this year?	☐ No	☐ Yes	Discharge Date: / /
Was your injury caused by a motor vehicle accident or a work injury?	☐ No	☐ Yes	Injury Date: / /

SYMPTOM SURVEY

What are your chief problems or symptoms?				
What caused the problems or symptoms?				
When did the problems or symptoms begin?				
Have you seen another doctor for these problems?	☐ No	☐ If yes, who?		
What tests/procedures have been performed?	☐ X-Ray	☐ MRI	☐ Surgery *(date)*	☐ Hospitalization *(date)*
Have you had these problems or symptoms in the past?	☐ No	☐ Yes Explain.		
Have you tried any other types of treatment?	☐ No	☐ Yes Explain.		
Onset of Pain:	☐ Sudden	☐ Gradual *(How long?)*		
On a scale of 1 to 10, how would you rate your pain level?	*Mild* 1 2 3 4 5 6 7 8 9 10 *Severe*			
What aggravates your symptoms?				
What, if anything, gives you relief?				

Describe your pain. Mark (X) all that apply.

☐ Intermittent	☐ Recurring	☐ While Resting	☐ While walking	☐ During Exercise	☐ Other:
☐ Dull Ache	☐ Stabbing	☐ Tingling	☐ Sharp	☐ Throbbing	

PATIENT HISTORY

Do you have a pacemaker?	☐ No	☐ Yes Explain.
Do you use tobacco?	☐ No	☐ Yes Explain.
Do you have a history of substance abuse?	☐ No	☐ Yes Explain.

PATIENT HISTORY (continued)

Please mark (X) all of the items that apply to you now and in the past.

☐ Arthritis / Gout	☐ Depression / Anxiety	☐ Pregnancy	☐ Seasonal Allergies	☐ Headaches
☐ Autoimmune Disorder	☐ Dizziness	☐ Seizures	☐ Joint Dislocations	☐ Heart Disease
☐ Jaw Pain	☐ Whiplash	☐ Neck Pain / Spasms	☐ Chronic Fatigue	☐ Ligament Sprain
☐ Rheumatoid Arthritis	☐ Swallowing Difficulty	☐ Thyroid Problems	☐ Chest Pain	☐ Muscle Strain
☐ Cancer	☐ Hypertension	☐ Stroke	☐ Kidney Stones	☐ Osteoporosis
☐ Shortness of Breath	☐ Irregular Heart Beat	☐ HIV / AIDS	☐ Asthma / Bronchitis	☐ Mid-Back Pain
☐ Shoulder / Elbow Pain	☐ Wrist / Hand Pain	☐ Lower Back Pain	☐ Hip / Knee / Leg Pain	☐ Foot / Ankle Pain
☐ Abdominal Pain	☐ Diabetes	☐ Groin or Rectal Pain	☐ Female Disorders	☐ Urinary Problems
☐ Skin Problems	☐ Broken Bones	☐ Digestive Problems	☐ Nausea / Vomiting	☐ Irregular Bowels

List referring physician and all physicians you have seen regarding this condition:	List all past surgeries related to your condition:
List all current medications:	List all allergies and known drug allergies:

PRACTICE TERMS

Health Care Privacy Notice / Informed Consent / Cancellation Policy / Payment conditions

Welcome to our practice! We are commited to providing high-quality physical therapy, occupational therapy, and speech therapy services designed to support your recovery, enhance your abilities, and promote long-term physical health and independence. While we are dedicated to delivering the best possible care, you understand that no specific results can be guaranteed, and full recovery may not always be possible.
Our office and staff are committed to providing all patients, regardless of race, color, national origin, age, sex, disability, or religious or political beliefs, quality health care services delivered with dignity and concern.

Your health information may be used, stored, and/or shared as part of your permanent medical record maintained in this office. You may request a free photocopy of this document. Your signature confirms that you have read, understand, and agree to comply with the terms outlined in the Health Care Privacy Notice and all related policies, consents, terms, and responsibilities. You grant the physicians, therapists, and staff permission to use and share your confidential health information for your care, payment, and operations of this facility. We encourage you to direct any questions or concerns to our staff to prevent misunderstandings.

If you need to cancel or reschedule an appointment, we ask that you provide at least 24 hours' notice. Missed appointments or frequent cancellations without adequate notice may result in a fee and could impact your ability to schedule future visits. If you miss an appointment or have not been seen in some time, we may call or mail reminders. Please let us know if you do not wish to receive these communications.

Our office will verify your insurance benefits and submit claims on your behalf as a courtesy. However, this does not guarantee coverage or payment. You remain financially responsible for all services provided, regardless of your insurance status or benefit determination. This includes co-payments, deductibles, and any charges for services not covered or reimbursed by your insurance plan.

All account balances, including automobile and work injury claims, must be paid in full within 90 days of treatment. Patients are fully responsible for all money owed to this office regardless of settlement outcomes, attorney liens, or pending insurance claims. If a third party fails to pay within 90 days, the patient is responsible for the balance. Our office offers payment plan options for outstanding balances. If your account remains unpaid despite our efforts to arrange payment, your balance may be referred to a collections agency for further action.

Our facility follows federal and state privacy laws regarding your Protected Health Information (PHI). We may use and disclose your PHI for treatment, payment, and healthcare operations without your written authorization. You have the right to access your medical records, request amendments, and file complaints without retaliation. For full details, please review our posted Health Care Privacy Notice or ask for a copy.

Patient Consent

I understand that physical therapy and related services are not substitutes for medical treatment. While we aim to promote improvement, no specific outcomes can be guaranteed. There are risks associated with treatment, including but not limited to sprains, strains, fractures, drug reactions, or other adverse effects. I give my full consent for myself, or the minor for whom I am legally responsible, to receive treatment by a licensed provider of this facility. I also assign the facility the right to bill and collect payment directly from my insurance, attorney, or other third parties responsible for payment.

Patient Signature

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient	Name of Parent *(If patient is a minor.)*
Signature of Patient *(Parent must sign if the patient is a minor.)*	Date