CORNERSTONE
PHYSICAL THERAPY, INC.
& WELLNESS

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PATIENT REGISTRATION

Date_____ Patient Name_____ Birthdate_____

Social Security Number _____Marital Status_____ Sex_____

If Under 18: Guardian's Name_____ Birthdate_____

Address_____ City _____ State ___ Zip _____

Phone Number _____Cell_____

Email_____ Preferred Language_____

Race (optional)_____ Ethnicity (optional)___Hispanic ___Non-Hispanic

Employer_____Occupation_____

Employer's Address_____ Work Phone_____

Notify In Emergency_____Phone_____Relation_____

How did you hear about us?

Doctor: _____

Dentist:_____

Self-Referral: (circle one) Workshop Social Media Google Company Website Race/Event

Other: _____

Friend/Family: _____

Is this due to an automobile accident or a work-related injury? ____Yes ____No If yes, please provide a contact name (Adjuster, Case Manger), phone number, claim number, etc. in order for us to properly bill your claims:_____

_____

The information above is given to the best of my knowledge and represents my current information. Failure to supply correct information may result in the patient being responsible for services rendered.

_____ _____
Patient/Guardian Signature **Witness Signature**

_____ _____
Print Name **Print Name**

CANCELLATION POLICY

If you need to change or cancel your appointment for any reason, **we request at least 24 hours' notice. Failure to call within this time frame may result in a $50.00 fee not covered by insurance.** This fee will be due in full at your next treatment session. This advanced notice allows us to fill your slot with another patient in need of treatment. Repeated changes with or without notice or multiple cancellations will result in restricting your ability to schedule future appointments.

I understand and agree to the terms stated above.

_____ _____

Patient/Guardian Signature **Witness Signature**

_____ _____

Print Name **Print Name**

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I authorize Cornerstone Physical Therapy, Inc. to release all my (or my dependent's) records to: ***(Medicare & Medicaid patients must provide a primary care physician):***

City/State/Phone Number

Your family physician:

_____

Other physician/provider:

_____

Other physician/provider:

_____

Family Members/Friends:

_____

CONSENT TO TREAT:

_____ I authorize Cornerstone Physical Therapy, Inc. to administer all necessary treatments and care
(initial) required for my (or my dependent's) rehabilitation.

HIPAA DISCLOSURE STATEMENT:

_____ I acknowledge that I have been informed of the Provider Notice of Practices which is located in
(initial) the reception area of this facility.

PHONE CALL AUTHORIZATION:

I authorize Cornerstone Physical Therapy, Inc. to leave messages on my answering machine regarding relevant information. _____(Initial) _____(Decline)

I authorize Cornerstone Physical Therapy, Inc. to text message my cell phone for appointment reminders. I further understand that ***I cannot text message Cornerstone Physical Therapy, Inc. to cancel or reschedule my appointments, and that I must call the office to handle these matters.***

_____(Initial) _____(Decline)

I understand and agree to all the terms stated above.

_____ _____

Patient/Guardian Signature **Witness Signature**

_____ _____

Print Name **Print Name**

PATIENT HEALTH QUESTIONNAIRE

Name: _____ Preferred Pronoun: _____ Date: _____

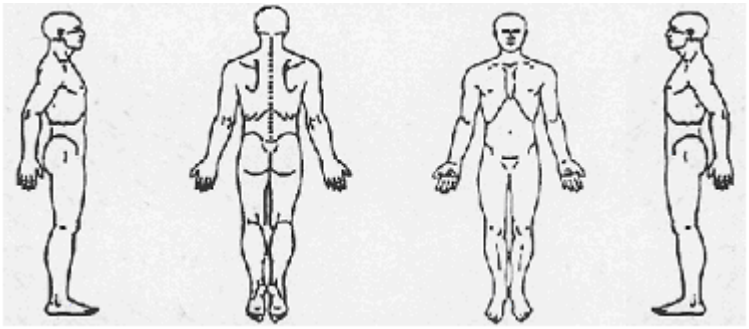
In the spaces below, please describe your major complaint.
Please describe your current complaint or limitation: _____

Please describe how your problem began:_____

Please tell us when your condition started:_____Specific Date if possible:___/___/___
Did you have surgery? ☐ No ☐ Yes Date____/____/____

Please describe the nature of your pain:

☐Sharp Pain ☐Constant (76%-100%)
☐Dull (Pain)Ache ☐Frequent(51%-75%)
☐Throbbing ☐Occasional (26%-50%)
☐Numbness ☐Intermittent (25% or less)
☐Shooting
☐Burning ⇨⇨⇨**MARK ON THE PICTURES WHERE**
☐Tingling **YOU HAVE PAIN OR OTHER SYMPTOMS**



Indicate the intensity of your ***pain at rest:*** (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your ***pain with movement*** : (NO PAIN) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)
Since this condition began, your symptoms have: ☐decreased ☐ not changed ☐ increased

Your symptoms are worse in: ☐Morning ☐afternoon ☐night ☐ increased during the day ☐same all day

Have you been treated in the past for the same problem? ☐ Yes ☐ No
If yes, who did you see for that condition? ☐MD ☐Physical Therapist ☐Occupational Therapist ☐Chiropractor ☐Other

When and what treatment did you receive? _____
Occupation:_____Has your work status changed because of this condition? ☐ Yes ☐ No

If you have ever had a listed condition in the past, please check the PAST column. If you are presently troubled by a particular condition, check it in the present column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

Past	Present	
☐	☐	High blood pressure(401.9)
☐	☐	Angina(413.9)
☐	☐	Heart Attack(410.9)
☐	☐	Stroke(436)
☐	☐	Asthma(493.9)
☐	☐	HIV/AIDS(042)
☐	☐	Cancer(199.1)Location_____Date_____
☐	☐	Tumor(229.9)
☐	☐	Systemic Lupus(710.0)
☐	☐	Hepatitis(573.3)
☐	☐	Epilepsy(349.5)
☐	☐	Diabetes(250.0)
☐	☐	Rheumatoid Arthritis(714.0)
☐	☐	Arthritis(716.9)
☐	☐	Pregnancy
☐	☐	Other_____
☐	☐	Tobacco(305.1)packs/day_____
☐	☐	Drug or alcohol Dependence(303.9)

Hospitalization/ Surgical procedures(List if not described elsewhere)_____
_____
_____
Medications:_____
_____
Allergies:_____
_____
_____
Any other medical conditions we should be aware of:_____
_____
_____

Patient's Signature_____