



The Overlook at Lake Julian
600 Julian Lane, Suite 660, Arden, NC 28704

1201 Bleachery Blvd, Suite 201
Asheville, NC 28803

Newbridge Commons
218 Elkwood Ave, Suite 103, Asheville, NC 28804

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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 48 hours' notice.** **Failure to call by 12 pm on the day prior to your appointment 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, 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 the all of 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: _____

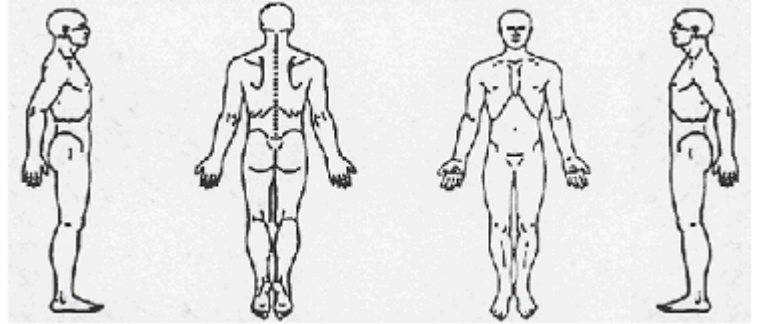
Please tell us when your condition started: _____ Specific Date if possible: ___/___/___

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
- Tingling

⇒ ⇒ ⇒ **MARK ON THE PICTURES WHERE 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			
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure(401.9)	Hospitalization/ Surgical procedures(List if not described elsewhere) _____ _____	
<input type="checkbox"/>	<input type="checkbox"/>	Angina(413.9)		
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack(410.9)		
<input type="checkbox"/>	<input type="checkbox"/>	Stroke(436)		
<input type="checkbox"/>	<input type="checkbox"/>	Asthma(493.9)		Medications: _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS(042)		Allergies: _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer(199.1)Location _____ Date _____		Any other medical conditions we should be aware of: _____ _____
<input type="checkbox"/>	<input type="checkbox"/>	Tumor(229.9)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus(710.0)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis(573.3)		_____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy(349.5)		
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes(250.0)		
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis(714.0)		
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis(716.9)		
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy		
<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco(305.1)packs/day _____		
<input type="checkbox"/>	<input type="checkbox"/>	Drug or alcohol Dependence(303.9)		

Patient's Signature _____