



PATIENT REGISTRATION FORM Date: _____

Patient Information

First Name:	MI:	Last Name:
Address:	City:	State/Zip:
Date of birth:	Age:	Gender: M F
Cell:	Home:	Email:
How would you like to receive appointment reminders? (Please Circle) Cell Call Cell Text Email		

Emergency Contact Information

First Name:	Last Name:	Relation:
Cell:	Home:	Email:

Parent/Guardian Information (If patient is a minor)

First Name:	Last Name:	Relation:
Address:	City:	State/Zip:
Cell:	Home:	Email:

Injury/Condition Information:

Condition:	Date of onset:
Was this an injury? YES NO	Injury area (If applicable):
Type of injury (please circle): Sport Work Accident Illness N/A Other:	
Was this an auto accident? YES NO	A work accident? YES NO If so, is there litigation involved? YES NO
What are your personal goals/outcomes you wish to achieve from physical therapy?	

How did you hear about us? (Please Circle)

Friend/Former Patient Physician Marketing Ad Internet Search Facebook Instagram Other: _____

I certify that all the information provided herein is true and correct.

Patient/guardian name (Print)

Patient/guardian signature

Date:

Witness name (Print)

Witness signature

Date:



HEALTH HISTORY QUESTIONNAIRE Date: _____

Welcome to T3 Physical Therapy! Please take a few minutes to let us know how we can help you. This will allow us to develop a treatment plan to meet your personal needs. If you have any questions as to how to complete this form, please leave that section blank and ask the therapist for help. Thank you and we look forward to serving you.

<p>PAIN SCALE (1-10) 0= None 5= Moderate 10= Extreme Current: _____ Best: _____ Worst: _____</p>	<p>AGGRAVATING FACTORS (Activities that increase your pain)</p>
<p>DESCRIPTION OF PAIN</p> <p> <input type="checkbox"/> Burning <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Constant <input type="checkbox"/> Sharp <input type="checkbox"/> Worse at Night <input type="checkbox"/> Dull/Achy <input type="checkbox"/> Shooting <input type="checkbox"/> Worse in Morning <input type="checkbox"/> Intermittent <input type="checkbox"/> Throbbing <input type="checkbox"/> Other: _____ </p>	<p>EASING FACTORS (Things that decrease your pain)</p>
<p>On the diagram below, please shade in the area of your body where you have pain, numbness, and/or tingling. Describe the pain (i.e. burning, aching, sharp, dull) next to the shaded area.</p> <div style="text-align: center; margin-top: 20px;"> </div>	<p>GENERAL HEALTH STATUS</p> <p> <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Other: _____ </p>
<p>CURRENT ACTIVITY LEVEL</p> <p> <input type="checkbox"/> Sedentary <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Other: _____ </p>	

I certify that all the information provided herein is true and correct.

Patient/guardian name (Print)

Patient/guardian signature

Date:

Witness name (Print)

Witness signature

Date:



HEALTH HISTORY QUESTIONNAIRE CONT'D

TREATMENTS RELATED TO CONDITION

- | | |
|--|---|
| <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Occupational Therapist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Orthopedist |
| <input type="checkbox"/> Family Practitioner | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Pediatrician |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Podiatrist |
| _____ | <input type="checkbox"/> Primary Care Physician |

DIAGNOSTIC TESTS

- | | |
|---|--|
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Blood Tests | <input type="checkbox"/> Myelogram |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> NCV |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Pulmonary Function Test |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Stress Test |
| <input type="checkbox"/> Doppler Ultrasound | <input type="checkbox"/> X-Rays |
| <input type="checkbox"/> EMG | |
| <input type="checkbox"/> Other: _____ | |
| _____ | |

FUNCTIONAL LIMITATIONS

- | | |
|---|--|
| <input type="checkbox"/> ADLs | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Ambulation/Mobility | <input type="checkbox"/> Self-Care |
| <input type="checkbox"/> Bending | <input type="checkbox"/> Sitting |
| <input type="checkbox"/> Community Activities | <input type="checkbox"/> Sleeping |
| <input type="checkbox"/> Lifting/Carrying | <input type="checkbox"/> Sports |
| <input type="checkbox"/> Pulling | <input type="checkbox"/> Squatting |
| <input type="checkbox"/> Pushing | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Stairs | <input type="checkbox"/> Recreational Activities |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Work |
| _____ | |

MEDICAL/SURGICAL HISTORY

- | | |
|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Circulation / Vascular | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psycho-Social |
| <input type="checkbox"/> *Denies PMH | <input type="checkbox"/> Repeated Infections |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Developmental Problems | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Ulcers/Stomach Problems |
| <input type="checkbox"/> Infectious Disease | |
| <input type="checkbox"/> Other: _____ | |
| _____ | |

MEDICAL SYMPTOMS (PAST YEAR)

- | | |
|--|---|
| <input type="checkbox"/> Bowel Problems | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Joint Pain or Swelling |
| <input type="checkbox"/> Coordination Problems | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Pain at Night |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Dizziness/Blackouts | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Weak Arms or Legs |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Weight Loss/Gain |
| _____ | |

CURRENT MEDICATION

- | | |
|--|--|
| <input type="checkbox"/> Advil | <input type="checkbox"/> Dietary Supplements |
| <input type="checkbox"/> Aleve | <input type="checkbox"/> Herbal Supplements |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen |
| <input type="checkbox"/> Cortisone Injection | <input type="checkbox"/> Naproxen |
| <input type="checkbox"/> Decongestants | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Other: _____ | |
| _____ | |

HEALTH HISTORY QUESTIONNAIRE CONT'D

Please list all surgeries, and the year they occurred.

Are you currently experiencing any flu-like symptoms? (i.e. fever, coughing, etc.) YES NO
If yes, what symptoms?

I certify that all the information provided herein is true and correct.

Patient/guardian name (Print)

Patient/guardian signature

Date:

Witness name (Print)

Witness signature

Date:



SOCIAL/HEALTH HABITS

Date: _____

SMOKING

Does NOT currently smoke tobacco

DOES currently smoke tobacco

How many packs per day? _____

How many cigars/pipes per day? _____

Smoked in the past Year quit: _____

ALCOHOL

Do you ever drink alcohol? YES NO

If yes, how many days per week to you drink, on average? _____

How many drinks do you have on an average day? _____

EXERCISE

Do you exercise beyond daily activities and chores? YES NO

Describe the exercise: _____

On average, how many days per week do you exercise? _____

SOCIAL STATUS

- Single
- Married
- Divorced
- Lives Alone
- Lives with Family
- Lives with Roommate
- Widow/er
- Other:

Occupation: _____

Physical requirements of your work: _____

Sports and fitness activities: _____

Which is your dominant side? RIGHT LEFT

Do you use recreational drugs? YES NO

SOCIAL/HEALTH HABITS CONT'D

Do you smoke, Vape, or chew tobacco? YES NO

Are you allergic to latex, or tape? YES NO

Please list all other allergies: _____

I certify that all the information provided herein is true and correct.

Patient/guardian name (Print)

Patient/guardian signature

Date:

Witness name (Print)

Witness signature

Date:



CONSENT TO TREATMENT

I consent to be treated by Jason LaBarthe, PT, MPT, OCS, and T3 Physical Therapy for the injury/illness for which I have consulted. In doing so, I voluntarily consent to the rendering of such care within the physical therapist scope of practice. Initials: _____

I understand, acknowledge and affirm that such a rehabilitation and related services may involve body contact, touch and/or direct contact of a sensitive nature. Initials: _____

I acknowledge that no guarantees have been made to me as to the results of examination or treatment by Jason LaBarthe, PT, MPT, OCS and T3 Physical Therapy. Initials: _____

I understand and agree that Jason LaBarthe, PT, MPT, OCS and T3 Physical Therapy provides in-home physical therapy treatment for my convenience. I hereby consent to allow Jason LaBarthe and T3 Physical Therapy to come into my home to provide such physical therapy services. Initials: _____

Treatment of Minors

I, as a parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I, or my spouse are required to remain on the premises during any such treatment. Initials: _____

Females Only

I do hereby agree and understand that at least one other adult is required to remain on the premises during any such treatment. Initials: _____

Liability

I understand and agree that Jason LaBarthe, PT, MPT, OCS, and T3 Physical Therapy are not responsible for loss or damage to personal valuables. Initials: _____

Waiver and Release

I hereby release, discharge and acquit T3 Physical Therapy, its agents, representatives, affiliates, employees, from any and all liability, claim, demand, damage, cause of action or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, emergency medical technician, physician or urgent care services. Initials: _____

Release of Information

I authorize T3 Physical Therapy to communicate directly regarding my care with my other health care providers, my insurance company, and the following individuals/organizations I have listed below. A complete copy of HIPAA compliance guidelines is available on request. Initials: _____

I acknowledge I have received a copy of the notice of privacy practices. Initials: _____

Patient/guardian name (Print)

Patient/guardian signature

Date:

Witness name (Print)

Witness signature

Date:



FINANCIAL POLICY

I understand and agree I am financially responsible for the full payment for the services I receive. Initials: _____

I understand and agree that payment is due in full at the time services are rendered. Initials: _____

I understand and agree that the only accepted forms of payment are cash, check, debit card, or credit card.
Initials: _____

I understand and agree that T3 Physical Therapy will not attempt to bill my insurance company for services I receive. Initials: _____

I understand and agree that I will receive a receipt and/or superbill within 24 hours of my treatments, and it is my responsibility to seek reimbursement from my insurance company if able. Initials: _____

I understand and agree that T3 Physical Therapy does not guarantee I will receive any reimbursement from my insurance company, even if I submit a receipt and/or superbill provided by T3 Physical Therapy. Initials: _____

I understand and agree T3 Physical Therapy does not accept auto accident liens. Initials: _____

MISSED APPOINTMENTS

Broken appointments or late notice cancellations are a significant cost to T3 Physical Therapy. Cancellations are required at least 24 hours prior to the scheduled appointment, to give T3 Physical Therapy adequate time to offer the timeslot to another patient. I agree and understand that T3 Physical Therapy reserves the right to charge \$50 for missed appointments. Exceptions may be made in certain extenuating circumstances including but not limited to a first-time broken appointment or late notice cancellation due to illness or family emergency. Initials: _____

Patient/guardian name (Print)

Patient/guardian signature

Date:

Witness name (Print)

Witness signature

Date:

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

T3 Physical Therapy, LLC is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care in the event of an emergency.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Change of Ownership

In the event that T3 Physical Therapy, LLC is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that T3 Physical Therapy, LLC is not required to agree to the restriction that you requested.



NOTICE OF PRIVACY PRACTICES CONT'D

You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request

You have the right to inspect and copy your health information.

You have a right to request that T3 Physical Therapy, LLC amend your protected health information. Please be advised, however, that T3 Physical Therapy, LLC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

You have a right to receive an accounting of disclosures of your protected health information made by T3 Physical Therapy, LLC.

You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide T3 Physical Therapy, LLC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print) _____

Signature _____

Date _____



TEXT AND EMAIL DISCLAIMERS

May we send you text reminders for your appointment reminders to the cell phone number you have provided? By marking "Yes" below you acknowledge that you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

Yes No

Initials: _____

May we send you text messages the day after physical therapy sessions to inquire about the status of your symptoms and to determine how your symptoms responded to the previous day's treatment? By marking "Yes" below you acknowledge that you understand that text messages may NOT be secure, with a risk of unauthorized access to your information.

Yes No

Initials: _____

May we send you emails relating to your care with us? By marking "Yes" below you acknowledge that you understand that email messages may NOT be secure, with a risk of unauthorized access to your information.

Yes No

Initials: _____

May we send you emails including your evaluation report, superbills for each session, progress notes, and discharge summary? These documents will contain personal information including your name, date of birth, and physical therapy diagnoses. By marking "Yes" below you acknowledge that you understand that email messages may NOT be secure, with a risk of unauthorized access to your information.

Yes No

Initials: _____

Superbills require your social security number, address, policy carrier, and policy number. It is the policy of T3 physical therapy that we will not fill in that information for personal information security reasons. By marking "Yes" below you acknowledge that you understand you will need to fill out that information on your own before submitting to your insurance company for reimbursement.

Yes No

Initials: _____

Patient/guardian name (Print)

Patient/guardian signature

Date: