PATIENT REGISTRATION FORM

Patient Name (First, MI, Last)	Date of Birth	Sex ☐M ☐F	Home Phone
Present Address City State Zip			Cell Phone
Date of Occurrence	E-mail Address		Social Security #
Cause of Injury: ☐Auto Accident ☐ N/A ☐Workers' Comp	Doctor's Diagnosis		Referring Physician
Primary Insurance	Subscriber # or ID #		Group or Plan #
Secondary Insurance	Subscriber # or ID #		Group or Plan #
Have you had any therapy, anywhere, this calendar year? ☐Yes ☐No			# of visits?
Are you receiving care from any Home Health service at this time? ☐Yes ☐No			What for?

IF INJURED IN AN **AUTO ACCIDENT PLEASE FILL OUT BOX BELOW**

Auto Insurance being billed	Claim #	Adjuster or Agent Name	Phone #

IF INJURED IN A **WORK RELATED ACCIDENT PLEASE FILL OUT BOX BELOW**

Employer or Insurance Company	Claim #	Adjuster or Employer Contact	Phone #

Authorization to Collect for Services Rendered

I hereby authorize Agape Therapy to furnish any information to any and all insurance carriers concerning me or my dependents. I also hereby assign to Agape Therapy all payments for services rendered to me or my dependents. I understand that I am solely responsible for any charges incurred that are not subsequently covered by my insurance.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement I have received a copy of Agape Therapy's Notice of Privacy Practices.

Cancellation/No Show Policy:

There will be a $25 fee charged to any patient who doesn't keep an appointment as scheduled, or fails to notify us of a cancellation **prior to 5:00 p.m**. the previous business day.

Informed Consent

The patient may be under the control of his/her physician and consents to any treatment or procedures rendered the patient by this agency under the general and specific instructions of the physician. It is further understood that the agency is hereby relieved of any and all liability occurring from the performance of the physician's instructions. I request and authorize the staff to provide me with physical, occupational and or speech therapy and to perform any procedures now ordered or such additional procedures as may be authorized by my physician.

X **Signature to acknowledge all above is true and understood** : ____ **Date:** ___________

*If you signed as the **patient's representative**, please print your name, describe your relationship to the patient below.*

____   ____

Name   *Relationship to Patient*

AGAPE therapy REHAB RESTORE RECLAIM

PATIENT MEDICAL HISTORY FORM

(please fill out thoroughly)

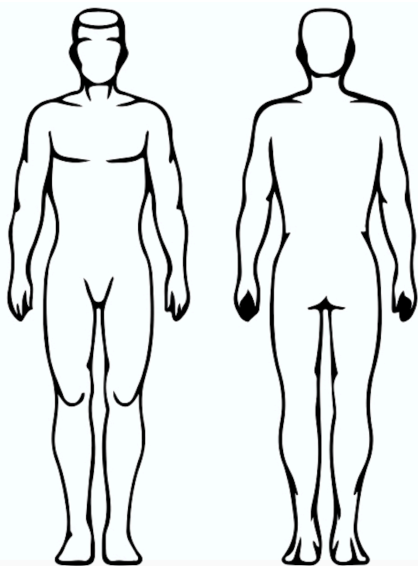
Name	Sex	Today's Date	Birthdate	Emergency Contact and Phone #
Address	Email		Cell Phone	Patient Employer: Duty: ☐ PT ☐ FT
Doctor Name Doctor Location	**Have you had therapy anywhere this year?** ☐ yes ☐ no If yes: # of visits _____ **Are you getting in home care?** ☐ yes ☐ no			**Is this condition:** 1. Fall related? ☐ yes ☐ no 2. Automobile related? ☐ yes ☐ no 3. Work related? ☐ yes ☐ no

How do you learn best?
☐ hearing ☐ seeing ☐ doing

Do you have difficulty:
☐ hearing ☐ seeing ☐ speaking ☐ reading

How did you hear about us? (circle)
☐ doctor referred (write name): ☐ tv commercials ☐ drive by ☐ been here before ☐ friend ☐ other:

WHAT IS YOUR CURRENT CONDITION/ISSUE?____



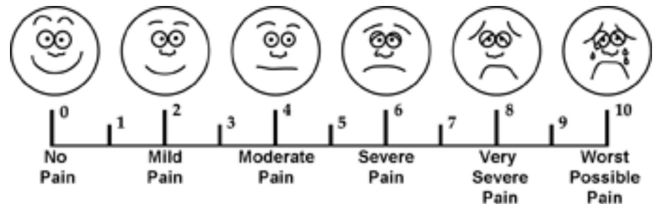
Is this the first episode?
☐ yes ☐ no If no, when was the first episode?

Symptoms start date:

Symptoms are:
☐ constant ☐ intermittent ☐ chronic ☐ new
☐ getting better ☐ getting worse ☐ same

Where is your pain?
Mark on the person where your pain is and note type of pain.

Pain Intensity:
____/10 current
____/10 at best
____/10 at worst



Pain gets better:
☐ bending ☐ sitting ☐ turning ☐ standing ☐ walking ☐ lying ☐ AM ☐ as day progresses ☐ when still ☐ moving

Pain gets worse:
☐ bending ☐ sitting ☐ turning ☐ standing ☐ walking ☐ lying ☐ AM ☐ as day progresses ☐ when still ☐ moving

What is limited because of current complaint:
☐ sleep ☐ self-care ☐ housework ☐ reaching ☐ lifting ☐ sitting ☐ standing ☐ bending ☐ community access ☐ work

Sleep position:
☐ back ☐ belly ☐ right side ☐ left side ☐ recliner ☐ restless ☐ other:

Any other notes:

-MEDICAL HISTORY-

(Please fully answer these questions; you would be surprised how this helps us to help you!)

Other Recent Symptoms		
Have you recently noted any of the following? (check all that apply)		
Extreme fatigue	Anxious or down	Shortness of breath
Constipation/diarrhea	Dizziness/light headed	Numbness/tingling
Visual changes	Muscle weakness	Heartburn/indigestion
Incontinence	Bowel/bladder changes	Unexplained cough
Fainting	Unexplained weight gain/loss	Swelling
Nausea/vomiting	Rapid heart rate/palpitations	Brain fogginess
Fever/sweats/chills	Recent onset of headaches	Other:

Past Diagnosis(s)		
Have you ever been diagnosed with any of the following? (check all that apply)		
Cancer	Asthma	Bladder/urinary/kidney
Diabetes I or II	Thyroid condition	GI disease
Cardiovascular	Bone/joint infection	Depression/anxiety
Respiratory	Seizures	Neurological disease
Vascular(Strokes, etc)	Chronic headaches	Visual/hearing impairments
Infectious disease(s)	Arthritis	High/low blood pressure
TB/HIV/Hepatitis	Chest pain	Other:

Please list ALL	
Surgeries/injections.	
Imaging. Check and date:	☐ Xray ☐ CT Scan ☐ MRI ☐ other:
Other practitioners you have seen for treatment:	
Falls or traumas:	
Do you have allergies to:	☐ latex ☐ cold ☐ heat ☐ medications Any other allergies?

Family History in regard to current condition: (relationship to patient and condition)

List current medications/vitamins/supplements: You can bring in a document containing this if you wish.

Name *Purpose*

Health Considerations:

Smoking: ☐ currently ☐ history

Alcohol: ☐ currently ☐ history __drinks/week

Pregnancy: ☐ currently __# of weeks along __# of total pregnancies

To the best of my ability, I have included all pertinent medical information. I also give consent to receive therapy by qualified staff and/or participate in fitness or physical activity opportunities.

Patient/Guardian Signature: ______________________________ Date: ______________

-Agape thanks you for your completeness; we promise it will help give you great care!