ASSOCIATES IN PHYSICAL THERAPY
AIPT EAST WENATCHEE, WA

PATIENT REGISTRATION

PATIENT

First Name:_____ MI _____ Last Name _____ DOB: ___/___/____

Address _____City_____State___ Zip_____

Primary Phone _____ Secondary Phone _____ Gender ☐ Male ☐ Female

Email _____ Appointment Reminders ☐ Phone ☐ Text
(for clinic use only, not for marketing or third-party use)

Responsible Party (if other than patient): _____ Relationship_____

Address _____ Phone _____

EMERGENCY CONTACT

Name _____Relationship _____Phone _____

PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally be kept confidential. I understand that a copy of this policy is available at my request and on our website.

Signature_____ Date_____

I give permission for the following individual(s) to request treatment or account information:

_____

_____ Initials_____

CANCELLATION POLICY

Patients are seen at AIPT by appointment only. Scheduling is based on a first come, first served basis. It is advisable for you to schedule your appointments a few weeks in advance.

Your appointment time is very important to us. In the event you need to cancel your appointment, we require at least 24-hour notice. If you cancel, and we do not get a 24-hour notice, or you do not arrive for your scheduled appointment (no-show), you may be assessed a $35 fee. This fee will not be covered by your insurance company.

ACKNOWLEDGEMENT

Patient's or authorized person's signature:

- I authorize the release of any medical records or other information necessary to process claims.
- I authorize payment of medical benefits to Associates in Physical Therapy, PLLC.
- I am financially responsible for any balance due on all covered or non-covered services.

Signature_____ Date: _____
(Parent/Guardian if patient is a minor)

ASSOCIATES IN PHYSICAL THERAPY
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Name:_____ DOB:_____ Today's Date_____

Initial Evaluation Form

1. Main Complaint (Reason for your visit today): _____

2. When did it start?:_____Is it: __Improving __Getting Worse __Staying same

3. How did it begin?:

___Motor Vehicle Accident ___Work Related Injury ___ Sports/Exercise Injury

___Post-surgery ___ Unknown Cause ___ Chronic Condition/Illness

___ Other (Briefly explain):_____

4. What **increases** your symptoms?:

__Sitting __Standing __Walking __ Lying Down __Lifting __Bending __Squatting

__Reaching overhead __Coughing/Sneezing __Stress/Anxiety __Running/Jumping

__Other:_____

5. What **decreases** your symptoms?:

__Sitting __Standing __Walking __ Lying Down __Massage __Heat __Ice __Medication

__Other:_____

6. Is your sleep disturbed due to pain? Yes or No

(if yes please explain)_____

7. Have you had any recent tests or imaging (past 3 months)?

__ X-ray __MRI __CT Scan __EMG __Bone Scan __Blood Tests __Ultrasound

__Other:_____

8. Have you had any treatment for this problem? (if yes please list):

_____

9. Do you have a pacemaker or any metal implants? Yes or No

10. Please list any surgeries (Including approx. date):_____

_____

11. Please list any **prescription medications:**_____

12. Have you been diagnosed with any of the following conditions (circle all that apply)?:

Arthritis	Balance Problems	Bowel/Bladder Problems	Heart Condition
Lung Condition	Cancer	Depression/Anxiety	Diabetes
Dizziness/Fainting	Epilepsy/Seizures	High Blood Pressure	HIV/AIDS
Stroke	Vision Problems	Jaw Problems (TMJ)	Pregnancy (current)
Osteoporosis	Infection (current)	Other:_____	

13. Use of Tobacco: __ Never/Infrequent __Previously but quit __Current pack/day:___

14. Use of Alcohol: __ Never __Rarely __ Moderate (2-4 drinks per week) __Daily

15. Use of Caffeine: __Coffee __Tea __Sodas (Drinks per day:_____)

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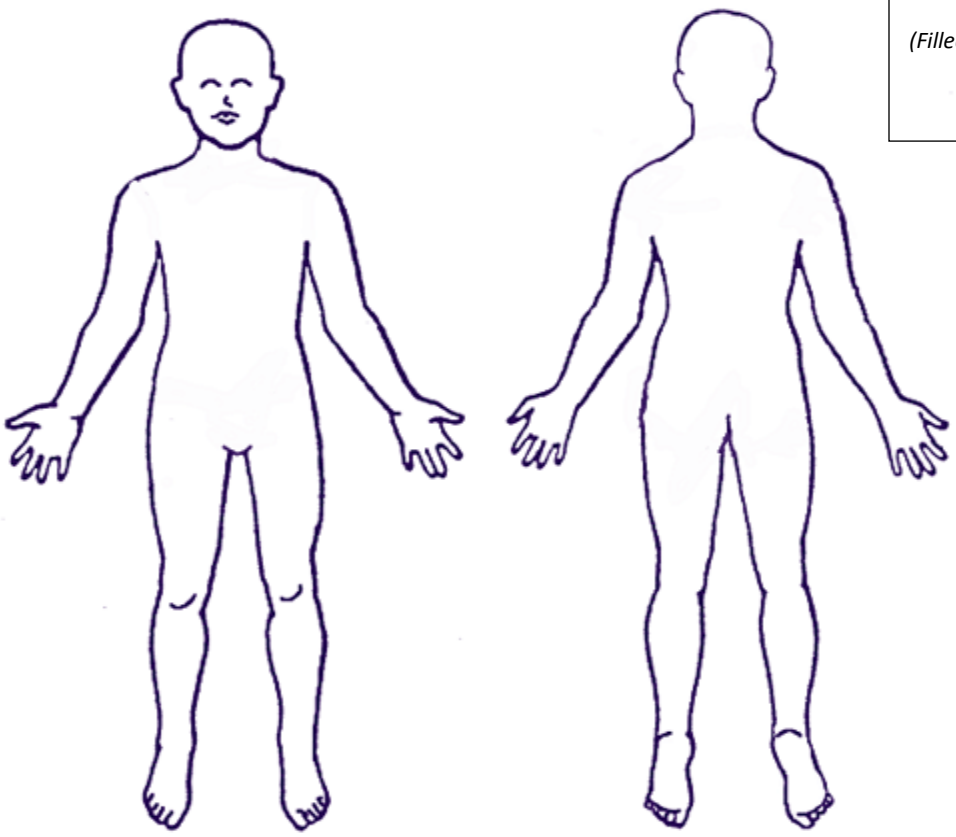
Name: _____

16. Exercise: __Never __Rarely __Weekly __Daily (Type of exercise:_____)
17. Employment: ___Working normal duty ___Currently light duty ___Not currently working ___Retired
    Job Title:_____ Physical Demands: __Sedentary/Computer __Light __Medium __Heavy
18. Which activities are difficult for you because of your pain complaint (circle all that apply)?:
    Sitting Standing Walking Reaching Lifting Pushing Pulling Carrying Sleeping Other_____
    Work Limitations/Restrictions:_____
19. Pain Assessment:
    Circle the number that represents your level of pain at **best and at **worst** in the last few days:

Pain at **Worst**:											
(No Pain) 0	1	2	3	4	5	6	7	8	9	10	(Requiring ER)
Pain at **Best**:											
(No Pain) 0	1	2	3	4	5	6	7	8	9	10	(Requiring ER)

Please Mark: x Pain, 0 Tingling, -- Numbness



Vital Signs:	Height:	BP:
(Filled in by staff)	Weight:	HR:
		SpO_2

_____ _____

Patient Signature *(or legal guardian/caregiver)* Date Therapist Signature Date