EVOLUTIONS THERAPY LLC
Physical Therapy • Occupational Therapy • Speech Therapy

PATIENT REGISTRATION FORM

Patient Last Name	First Name	Middle Initial	Date / /
Address		City	State / Zip Code
Birth Date / /	S.S. # - -	Gender: ☐ Male ☐ Female	Email Address:
Cell Phone:	Alternate Cell Phone:	I agree to receive emails and texts for therapy schedule. ☐ Yes ☐ No Initial:	
Parent or Legal Guardian Name	In Case of Emergency: Contact Name		Emergency Cell Phone
Referring Doctor	Who referred you to us: ☐ Doctor ☐ Former Patient ☐ Website ☐ Street Sign ☐ Insurance		

Insurance Information:

To hasten the process in your insurance verification please call the office. On your first visit, please hand in your insurance card and Driver's License so we can have a copy on file.

Auto / Attorney / Work Injury Claim:

We need a copy of the authorization letter. Please call us so we can verify the authorization.

Assignment of Insurance Benefits

I authorize my insurance benefits to be paid directly to Evolutions Therapy. I authorize the release of any information concerning my healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I agree to pay co-pays, co-insurance and deductibles as it applies to my insurance coverage. I understand that the balance on my account in this office is my responsibility whether my insurance company pays or not. I understand I will be assessed $40.00 charge for any checks returned by the bank.

_____

Patient / Guardian Signature Date

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Patient Last Name	First Name	Birth Date / /
Occupation	Employer Name	How many hours/week do you work?
Smoker: □ Yes □ No	Pregnant: □ Yes □ No	Are you taking blood thinners? □ Yes □ No

Past Medical History: Please check each condition

- □ Heart Problems
- □ High Blood Pressure
- □ Thyroid Problems
- □ Allergies/Asthma
- □ Difficulty Speaking
- □ Hydrocephalus
- □ Depression
- □ Diabetes
- □ Kidney Disease
- □ Lung Disease
- □ Double Vision
- □ Difficulty Swallowing
- □ Shunt
- □ Cancer
- □ Stroke
- □ Liver Disease
- □ Circulatory Problems
- □ Dizziness
- □ Seizure
- □ Baclofen Pump
- □ Hearing Difficulties
- □ Osteoarthritis
- □ Rheumatoid Arthritis
- □ Fibromyalgia
- □ Osteoporosis
- □ Epilepsy
- □ Drop Attacks

Cancer Related Questions: □ Chemotherapy □ Radiation Therapy	Have you had an X-ray, MRI or other imaging study? □Y □ N

Surgical History:

□ Back □ Knee □ Hip □ Shoulder □ Neck □ Amputation _____
□ Mastectomy □ Other: _____

Currently I am experiencing (Please circle all that apply):

- □ Unexplained weight loss
- □ Difficulty Swallowing
- □ Poor balance (falls)
- □ Difficulty sleeping
- □ Numbness or Tingling
- □ Shortness of breath
- □ Nausea/Vomiting
- □ Changes in Appetite
- □ Dizziness
- □ Changes in Bowel and Bladder Function
- □ Pain
- □ Headaches

Medications:

If you have a list, we can make a copy of it. We need the full list of current medications and dosages.

_____
_____
_____

CONSENT:

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services.

_____
Patient / Guardian Signature Date