BURBANK THERAPY CENTER • PATIENT REGISTRATION FORM

Welcome to our facility. To serve you properly, we will need the following information. **(PLEASE PRINT)**

Patient's Name	**Sex** M □ F □	**Birth Date** **Age** _____	**Marital Status** Single □ Married □ Widowed □ Divorced □
Residence address **City**	**State** **Zip**	**Home Phone**	**Patient's Social Security#**
Person responsible for this insurance **Self** □ **Spouse** □		**Responsible Party's Birth Date**	
Person to contact in case of emergency: **Phone number**		**Relationship to patient**	
ARE YOU CURRENTLY EMPLOYED Y □ N □ If no proceed to insurance	**Occupation**		**How long at current employer?**
Name of Employer **Address**			**Business Phone Number**
E-mail address:			

MEDICARE and INSURANCE INFORMATION (Skip if you bring an insurance card)

Medicare YES □ NO □	**Medicare Number:**		**Effective Date**
Primary Insurance Number **Address**		**Policy#** **Group#**	**Effective Date**
Secondary Insurance Number **Address**		**Policy#** **Group#**	**Effective Date**
Subscriber's Name **Address**			**Phone Number**
Subscriber's Date of Birth: **Subscriber's SSN:**		**Relationship to patient**	
□ **Personal Injury Accident** **Date of Accident** □ **Worker's Compensation** **Claim number**		**Carrier's name and address**	**Carrier's phone number** **Authorization number**
Attorney's Name **Phone number**		**Address**	

Assignment of Benefits / Information Release / Authorization to Treat:

I authorize payment of medical benefits for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the interdisciplinary team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure. I have received a copy of my Patients' Rights and Responsibilities.

_____ _____

Patient or Representative Signature Date

BURBANK THERAPY CENTER • PATIENT CONSENT & RIGHTS/RESPONSIBILITIES

Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that we make this notice available to you. When you sign and date this form you are agreeing that you were given a copy of this notice.

The notice states that we may use and disclose protected health information about you for your treatment, payment, and health care operations. In your notice, there is a complete list of examples of how we may disclose your personal health information without specific authorization from you.

Do we have your permission to:

Leave a message on your answering machine at home?	Yes	No	
Leave a message with someone at home? With whom:_____	Yes	No	
Leave a message at your place of work?	Yes	No	N/A
Perform Telehealth services as needed?	Yes	No	

Other than your doctor, please list full name & relationship of anyone with whom we may discuss your condition:

_____

Summary Of Patient's Rights And Responsibilities

We are committed to serving with compassion, skill and respect. As our patient, you have rights & responsibilities.

You have the *RIGHT:*

- To be treated with dignity and respect
- To know the names and professional status of people serving you
- To privacy & the confidentiality of your records
- To receive accurate information about your health-related concerns
- To know the effectiveness, possible side effects and problems of all forms of treatment
- To participate in choosing a form of treatment
- To receive education and counseling
- To consent to or refuse any care or treatment
- To select and/or change your healthcare provider
- To review your medical records
- To information about services and any related costs

You also have the *RESPONSIBILITY:*

- To seek medical attention promptly
- To be honest about your medical history
- To ask about anything you do not understand
- To follow health advice and medical instructions
- To report any significant changes in symptoms or failure to improve
- To respect clinic policies & keep appointments (or cancel in advance)
- To seek non-emergency care during regular business hours
- To provide useful feedback about services and policies

Patient Name:_____

_____ _____

Patient or Representative Signature Date

BURBANK THERAPY CENTER • MEDICAL HISTORY FORM

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

Prior *or* current occupation (*even if retired*): _____
Prior to current injury or illness were you: ☐ Working ☐ Retired ☐ On Disability

Are you receiving HOME HEALTH CARE? (does a nurse/therapist come to your house for ANY health care service**)**
☐ Yes ☐ No
Are you currently doing Physical Therapy anywhere else? ☐ Yes ☐ No

Do you get SHORT OF BREATH? ☐ Yes ☐ No; IF YES, does your breathing affect your mood? ☐ Yes ☐ No

Do you have joint or muscle PAIN or STIFFNESS? ☐ Yes ☐ No IF YES, where: _____

Do you have numbness, tingling, or burning sensations? ☐ Yes ☐ No

IF YES, WHERE: **Hands/Arms**: ☐ Right ☐ Left **Feet/Legs**: ☐ Right ☐ Left

Do you have hand tremors? ☐ Yes ☐ No IF YES: ☐ Right ☐ Left

Please check activities that cause the shortness of breath or other difficulties:

☐ Walking ☐ Climbing Stairs ☐ Exercising ☐ Lying Down ☐ Talking

☐ Carrying, lifting, pulling, pushing ☐ Reaching up and/or down

☐ Self-Care Activities (*self-feeding/eating; personal hygiene/grooming; dressing; bathing; toileting*)

☐ Home/Community Activities (*cleaning; cooking; shopping; caring for others/pets; work; volunteering*)

☐ Social or Recreational activities ☐ Other (*specify*):_____

Are daily activities: ☐ **INDEPENDENT** or do you need ☐ **ASSISTANCE** from others

Current Living Environment:

Do you live: ☐ Alone ☐ With spouse ☐ With Family Member ☐ With Friend/Roommate

Do you live in a: ☐ Single-level home ☐ Bi-level home ☐ Tri-level home ☐ Apartment ☐ Assisted Living

Do you have stairs in your home? ☐ Yes ☐ No; IF YES, how many inside? _____How many outside?_____

Is an elevator available? ☐ Yes ☐ No

Do you have a caregiver? ☐ Yes ☐ No IF YES, are they: ☐ Part-time ☐ 24/7

Is your memory: ☐ Good ☐ Fair ☐ Poor

Do you experience dizziness? ☐ Yes ☐ No ☐ Occasionally

Do you have a Pacemaker or Internal Ports? ☐ Yes ☐ No

Patient Name: _____ DOB: _____

Any precautions or medical restrictions? _____

Do you have a cough: □ No □ Occasionally □ Frequently; IF YES, is it: □ Dry □ Productive w/secretion

IF PRODUCTIVE, is secretion: □ Thin □ Thick □ Clear □ White □ Yellow □ Green □ Brown

DID YOU SMOKE: □ Yes □ No

If yes, when did you quit?_____ How many packs did you smoke a day?_____

Do you use oxygen? □ Yes □ No

IF YES: Liter:_____Name of Oxygen Provider: _____

□ All the time □ As needed

□ At home only □ At night only

Have you been hospitalized in the past year? □ Yes □ No

(IF YES, please describe including approximated dates, location and reason for hospitalization)

_____

_____

Please list the medications currently taken, dosage and how many times per day you take them:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Do you HAVE or USE the following assistive devices/ adaptive equipment?

□ Cane □ Walker with seat □ Folding front-wheel walker □ Manual wheelchair

□ Electric wheelchair/scooter

□ Shower chair/bench □ Safety grab bars in the shower/bathtub area □ Hand-held shower hose

□ Non-slip bath mat/strips □ High toilet seat □ Toilet commode □ Portable urinal

□ Long-handled bath sponge

□ Long-handled shoehorn □ Sock Aid/donner □ Elastic shoelaces

□ Reacher/grabber □ Dressing stick □ Button hook □ Special eating utensils

Patient Name: _____ **DOB:** _____

As of TODAY do you have difficulty, aggravating pain, weakness, fatigue or shortness of breath with or during:

Activities of Daily Living	**No Difficulty**	**Minimal Difficulty**	**Moderate Difficulty**	**Quite a bit of Difficulty**	**Extreme Difficulty, Unable to Do**	Not Doing
Self-Feeding / Eating: *cutting/serving food; holding utensils, cup; bringing food to mouth, swallowing*	☐	☐	☐	☐	☐	☐
Personal Hygiene: *oral hygiene, washing face/hands, deodorant/lotion application, hair combing/brushing, cleaning ears*	☐	☐	☐	☐	☐	☐
Grooming: *shaving, nail care, hair styling, make-up, skin care, etc.*	☐	☐	☐	☐	☐	☐
Toileting/Toilet hygiene: *able to reach for cleaning, lift underwear*	☐	☐	☐	☐	☐	☐
Upper body dressing: *t-shirt, blouse, shirt, dress, robe, jacket, sweater, underwear, tie, etc.*	☐	☐	☐	☐	☐	☐
Lower body dressing: *pants, skirts, underwear, socks/stocking, shoes*	☐	☐	☐	☐	☐	☐
Fasteners: *open/close buttons, zippers, buckles, snaps, Velcro closures; shoelaces*	☐	☐	☐	☐	☐	☐
Bathing / Showering: *washing & drying body and hair*	☐	☐	☐	☐	☐	☐
Care for Others: *family members, children*	☐	☐	☐	☐	☐	☐
Care for Pets: *type:* _____	☐	☐	☐	☐	☐	☐
Home Management: *house cleaning, making bed, taking garbage out, laundry, gardening*	☐	☐	☐	☐	☐	☐
Meal Preparation & Clean up: *cooking, washing dishes/countertops, opening jars, peeling, cutting; lifting pots/pans*	☐	☐	☐	☐	☐	☐
Shopping: *prolonged walking, lifting bags/items, pushing shopping cart, reaching up/down shelves; choosing, trying on, paying*	☐	☐	☐	☐	☐	☐
WORK / Job Performance: *describe*_____	☐	☐	☐	☐	☐	☐
Volunteer Participation: *describe*_____	☐	☐	☐	☐	☐	☐
SOCIAL / Recreational Activities: *describe*_____	☐	☐	☐	☐	☐	☐

Any activities that you gave up because of current condition or injury?_____

_____

Patient Name**:** _____ DOB: _____

CURRENT MEDICAL HISTORY (*check all that apply*):

Pulmonary/Lungs

- ▫ Obstructive sleep apnea
- ▫ Frequent bronchitis
- ▫ Emphysema
- ▫ Frequent pneumonia
- ▫ Asthma
- ▫ Pulmonary embolism
- ▫ Tuberculosis
- ▫ ILD/Pulmonary Fibrosis
- ▫ Bronchiectasis
- ▫ Pulmonary Hypertension
- ▫ Pulmonary Edema
- ▫ Sarcoidosis
- ▫ COPD
- ▫ COVID
  (if yes, please indicate the date: _____)

Cardiovascular

- ▫ History of angina or heart attack
- ▫ Hypertension
- ▫ History of arrhythmia
- ▫ History of poor circulation
- ▫ Rheumatic fever
- ▫ Congestive Heart Failure
- ▫ Heart valve disease
- ▫ Blood clots
- ▫ Pacemaker/ Defibrillator
- ▫ High Cholesterol

Muscle/Joint/Bone

- ▫ Osteoarthritis
- ▫ Osteoporosis
- ▫ Gout
- ▫ Rheumatoid arthritis
- ▫ Joint Replacement (where/when: _____)
- ▫ Fractured/broken bones (where:_____)
- ▫ Fibromyalgia
- ▫ Osteopenia
- ▫ Neck/Back/Shoulder pain
- ▫ Hip/Knee/Ankle pain (right, left or bilateral)

Neurologic

- ▫ History of stroke
- ▫ Seizures/Epilepsy
- ▫ TIA
- ▫ Dementia
- ▫ Vertigo
- ▫ Depression/Anxiety
- ▫ Peripheral Nerve Disease
- ▫ Insomnia
- ▫ Migraine
- ▫ Memory Loss
- ▫ Panic Attacks
- ▫ Neuropathy

General

- ▫ Weight gain/loss of 10+lbs. during last 6 months
- ▫ Cancer/Tumor: specify_____
- ▫ Possible pregnancy (women)

Eyes, Ears, Nose, Throat

- ▫ Blurred vision/glasses/contacts
- ▫ History of glaucoma or cataracts
- ▫ Loss of hearing
- ▫ Ringing in ears
- ▫ Sinus problems
- ▫ Allergies
- ▫ Frequent ear infections

Genitourinary

- ▫ Frequent or painful urination
- ▫ Bladder infections
- ▫ HIV infection

Skin/Breast

- ▫ Itching/Psoriasis
- ▫ Easy bruising
- ▫ Change in moles
- ▫ Abnormal mammogram
- ▫ Rashes
- ▫ Hives

Lymphatic/Hematologic/Metabolic

- ▫ Diabetes Mellitus
- ▫ Hyper/Hypo-thyroid
- ▫ Anemia
- ▫ Blood transfusion (if yes, when:_____)

Gastrointestinal

- ▫ Poor appetite
- ▫ Abdominal pain
- ▫ Kidney failure
- ▫ Trouble swallowing
- ▫ Diarrhea/Constipation
- ▫ Hemorrhoids
- ▫ Stomach Ulcers
- ▫ Nausea or vomiting
- ▫ Rectal bleeding or blood in stools
- ▫ Liver failure
- ▫ Diverticulitis
- ▫ Crohn's disease
- ▫ Hepatitis
- ▫ Colon polyps
- ▫ Prostate Disease
- ▫ Pancreatitis

Patient Name: _____

DOB: _____

BURBANK THERAPY CENTER • GOALS AND PSYCHOSOCIAL SERVICES

List goals or activities you would like to be able to do after completing therapy: _____

_____

_____

PSYCHOSOCIAL SERVICES:

Burbank Therapy Center offers psychosocial services. Would you like to be seen by our Licensed Clinical Social Worker (LCSW) for an evaluation?

- ▫ Yes If YES, please write a short reason for evaluation:
  _____
- ▫ No If NO, ***please sign declination below***:

I am aware of an LCSW on staff and psychosocial services at Burbank. At this point, I do not require a psychosocial evaluation.

_____

Patient or Representative Signature (***if declining LCSW Services***)

CERTIFICATION:

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT THE EVALUATION PROCESS WILL BE ANSWERED TO MY SATISFACTION. I WILL NOT HOLD THE PROGRAM OR ANY OF ITS STAFF RESPONSIBLE FOR ANY ERROR OR OMISSIONS THAT I HAVE MADE IN THE COMPLETION OF THIS FORM.

_____ _____

Patient Name DOB

_____ _____

Patient or Representative Signature Date

FOR OFFICE USE ONLY:

Explanation offered to patient/family/caregiver regarding our services, their purpose and our expectations:

□ Yes □ No; If no, was corrective action taken? □ Yes □ No