Neil Bastian, PT, LMT
503.697.0542 office
503.697.4895 fax
neil@bastianpt.com

Patient Registration

Name ____Birth date_______________ Age _____. M / F ?

Address ____

Phone __________________________Work ________________________Cell ________________________

Email __________________________ Occupation_________________________. Currently working? Y ___ N ___.

Referred by __________________ Primary MD _______________________ MD phone ____________________

Emergency contact phone/relationship: ____

Insurance Information: Your insurance card(s) can be copied at our office in lieu of completing this section.

Primary Insurance _______________________ ID # _______________________Group # ____________________

Insured's name _____________________________ Birth date (if different than above) _________________________

Address for claims ____ Phone _______________________

Secondary Insurance ________________________ ID # _____________________ Group # __________________

Insured's name __________________________________ Birth date (if different than above)_____________________

Provide 3rd party insurance information if appropriate for your situation.

Insurance company (wc, auto, etc.) ______________________________Policy # ___________________________

Claim # __________________________ Agent name _____________________ Phone ____________________

Financial Agreement

I, the undersigned, hereby authorize Bastian Physical Therapy, PC to release to the insurance company and/or attorney named above any information acquired in the course of my examination and treatment for the purposes of reimbursement of my financial obligation.

I hereby accept full financial responsibility for this account beyond the insurance obligations and contract agreements. Coverage by an insurance policy is no guarantee of payment. Should payment by your insurance company extend beyond 30 days, you will receive a bill for part or all of your charges, not to exceed limits set by your insurance policy .

Co-payments are due at each appointment unless other arrangements are made prior to treatment.

Statements are billed monthly and due upon receipt. If payment is delayed beyond15 days, the statement balance will accrue interest of 2% per month. The date of the first months' interest begins with the date of the initial statement.

____

Patient Signature Date

Neil Bastian, PT, LMT
503.697.0542 office
503.697.4895 fax
neil@bastianpt.com

Patient Health History

Name ____ M / F? _____ Age _______ Birth date _______________

What brings you to therapy? (Describe onset and behavior of your symptoms) ______________________________________

____

____

Date of : symptom onset / injury / surgery: ____.

Have you had these symptoms before? Explain ____

____

Rate the level of your symptoms using the rating of " 0 – 10", with 0 = painless, 10 = worst imaginable pain….

at initial onset? _______ currently at it's best _______ currently at it's worst _______

Are your symptoms: improving? Y_____ N_____, worsening? Y _____ N _____, or plateaued? _____ N _____.

How do you know? ____

What makes your symptoms: *(activity, position, time of day?)*

worsen? ____

reduce? ____

Other treatments prior to physical therapy? ____

Outcome of previous treatment(s) ____

Current medications and reason for taking: ____

____

Medical tests: X-rays _____ MRI _____ CT Scan ______ Bone scan _____ Stress test _____ Other __________

Outcome of test(s) ____

Any functional limitations as a result of your symptoms? ____

____

____

Current activity levels: High _____, Medium _____ or Low _____? How fit do you feel? ______________________

What do you do for recreation, hobbies?____

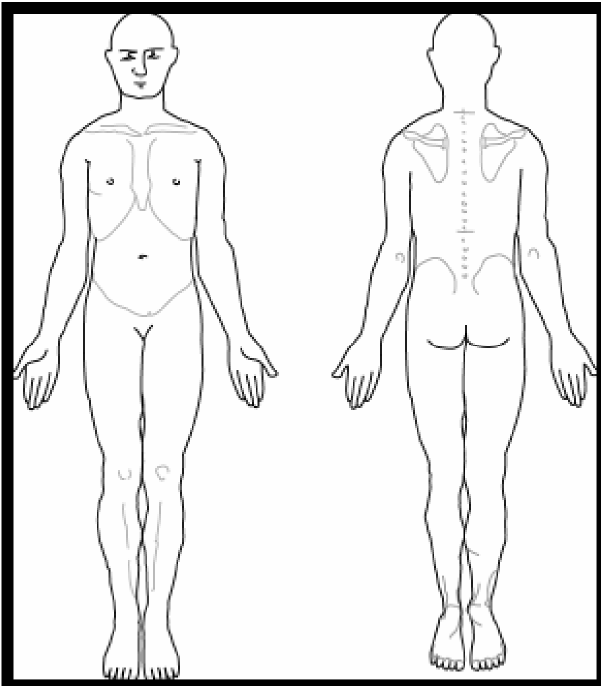
____

BASTIAN
Physical Therapy

Neil Bastian, PT, LMT
503.697.0542 office
503.697.4895 fax
neil@bastianpt.com

Patient Health History

MARK ON THE DIAGRAM BELOW ALL AREAS WHERE YOU FEEL YOUR SYMPTOMS.
USE THE KEY BELOW DIAGRAM TO MARK BODY FIGURES.



Key to symptoms

s = sharp pain
a = aching
p = pins & needles
d = dulled sensation
w = weakness
n = numbness (complete)
t = throbbing
b = burning
h/a = headache
o = other

CHECK ALL FOR WHICH YOU HAVE RECEIVED TREATMENT OR A DIAGNOSIS.

__ Cancer
__ Diabetes
__ Heart condition
__ Cardio-vascular disease
__ Head injury
__ High blood pressure
__ Arthritis
__ Infectious disease(s)
__ Multiple sclerosis
__ Epilepsy
__ Blood disorders
__ Broken bones
__ Loss of balance
__ Dizziness
__ Vertigo
__ Severe pain at night
__ Major organ problems (liver, stomach, kidney, etc)?
__ Sudden changes in bowel or bladder function?
__ Major surgeries (type and date)?_________________

____

____

____

____

____

____

Other conditions not listed above ___________________

____

____

____

____

Patient Signature **Date**