754 N College Rd, Ste D,
Twin Falls, ID 83301
(208)734-5313

2634 Addison Ave E
Twin Falls, ID 83301
(208) 326-2000

1015 Main,
Buhl, Id 83316
(208) 543-8887

PERSONAL INFORMATION

Last Name_____ First Name _____Middle Initial _____

Address_____City _____State_____Zip _____

Cell Phone_____Home Phone _____Work Phone _____

Social Security # _____Date of Birth _____ Sex: ☐Male ☐Female

Email Address_____ Consent to email? ☐Yes☐ No Age 0__ Height _____Weight_____

Occupation and employer_____ Currently Working?☐Yes☐No

Spouse/Parent_____Spouse/Parent Employer _____

Emergency Contact: Name_____ Phone_____Relationship _____

How did you hear about us? ☐Doctor ☐Friend/Relative ☐Google ☐Prior Patient ☐Insurance ☐Social Media ☐Other

INSURANCE/PAYER INFORMATION *Please provide all insurance, driver's license, and other payer info at time of check-in*

Injury/Issue due to: ☐Auto Accident ☐Work Injury ☐Accident ☐Sports ☐Unknown ☐Other

Will you be paying or using: ☐Personal Health Insurance ☐Auto Insurance ☐Worker's Compensation ☐Self Pay
☐Legal Payment ☐Other _____

GENERAL INJURY/CONDITION INFORMATION

What issue brings you to physical therapy?_____ Date of Injury _____

Did you have surgery ☐Yes ☐No Date of Surgery _____Type of Surgery_____

Referring Physician_____ Family Physician _____

Activity Restriction(s) per Doctor _____Current home health services? ☐Yes ☐No

Have you had prior physical therapy, occupational therapy, or chiropractic care this year? ☐Yes ☐No

Which of these tests have been done for this issue: ☐X-ray ☐MRI ☐CT/CAT ☐EMG ☐None ☐Other _____

Current Medications (or separate list)	Past Surgeries
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Office Use Only

*Treatment Dx:*_____ *Medical Dx:*_____ *DOI:*_____ *DOS:*___
*Entered by:*_____ *Therapist:*_____ *DOE:*_____

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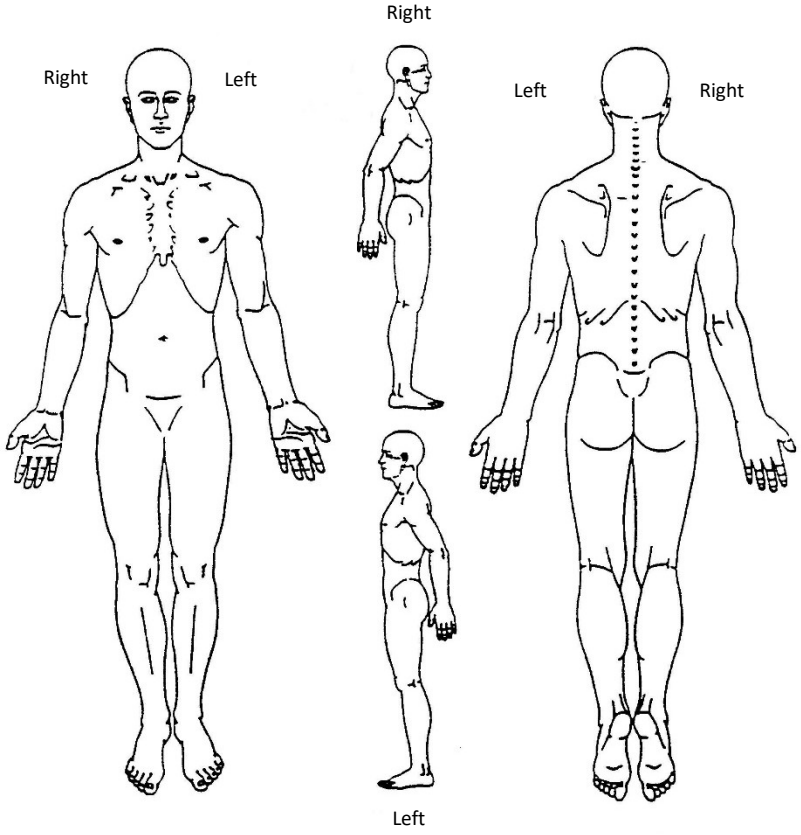
INJURY / CONDITION INFORMATION (CONTINUED) *Please mark/draw on the diagram where you feel symptoms:*

Please describe your symptoms that you drew on the diagram:



What would you like to gain from physical therapy?_____

PAST MEDICAL HISTORY *Do you currently have OR have a history of the following:*

☐ Heart Disease	☐ Alzheimer's	☐ Incontinence
☐ Chest Pain	☐ Parkinson's	☐ Cancer
☐ Stroke or TIA	☐ Fibromyalgia	☐ Hepatitis, TB, HIV, AIDS
☐ Congestive Heart Failure	☐ Neurological Disease	☐ Smoker
☐ Heart Attack	☐ Seizures	☐ COPD/Emphysema
☐ High Blood Pressure	☐ Anxiety/Panic Issues	☐ Current Infection
☐ Blood Clots	☐ Depression	☐ Asthma
☐ Peripheral Vascular Disease	☐ Traumatic Brain Injury	☐ Allergies
☐ Vision Problems	☐ Headaches	☐ Currently Pregnant
☐ Hearing Problems	☐ Migraines	Other _____
☐ Obesity	☐ Diabetes Type I or II	_____
☐ Arthritis	☐ Kidney Issues	_____
Osteoporosis (weak bones)	Prostate or Bladder Issues	_____

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PATIENT AUTHORIZATION

- ✓ **Payment** of your deductible and co-pay amount is required at time of service. We accept check, cash and credit cards. We will file Medicare, primary and secondary insurance if all information is furnished to us. Should financial problems arise, we encourage you tocontact our office for assistance in the management of your account. Financial arrangements can be made; we are here to help you.

- ✓ **Insurance is a contract between you and your insurance company**. We are not a party to this contract. We will file claims on your behalf from the information that you furnish us. If payment is made directly to you from your insurance you are responsible for sending us that payment.

- ✓ **I authorize CPR to release my records** to my insurance company, my referring physician and my attorney. I understand that these records will be held in strict confidence and will not be released to any unauthorized person.

- ✓ **I authorize payment** of medical benefits to undersigned physician or supplier for services rendered. Please let us know if you have any questions or concerns. Your signature below signifies your understanding and willingness to comply.

- ✓ **I give Center for Physical Rehabilitation my consent** to perform physical therapy services according to the recommended plan of treatment as discussed by my therapist.

- ✓ **HIPPA notification**: Our Notice of Privacy Practices describes how Center For Physical Rehabilitation, LLC may use and disclose protected health information. It also describes rights to access and control of protected health information. "Protected health information" is information about a person, including demographic information that may identify a person and that relates to their past, present or future physical or mental health or condition and related health care services. CPR, its employees, business associates and contractors are required to abide by the terms of this Notice of Privacy Practices. A full copy of our policy is available to you at any time. By signing below, you are giving us permission to disclose in written, electronic and oral formats as it is related to your medical needs, insurance requirements and payments to your account.

_____ _____

SIGNATURE **DATE**

CPR will not discriminate on the basis of Race, Color, Religion, National Origin, Handicap or Age.

PARENTAL CONSENT NEEDED IF **PATIENT IS UNDER THE AGE OF 18**

I hereby give my consent as a Parent/Guardian of_____for physical therapy evaluation and treatments rendered by the Center for Physical Rehabilitation. (sign here)_____.

The Center for Physical Rehabilitation offers a wide variety of services. If you would be interested in services other than what you were referred for, please ask your therapist for more information.

- Adaptive Equipment Needs
- Pediatric Therapy
- Aquatic Exercise Program
- Weight Loss/Exercise Program
- Wound And Burn Care
- Sports Performance
- Amputee Program
- Pre/Post Partum Program
- Home Safety Evaluation
- Neurological Rehab, For Stroke Or Brain Injury
- Incontinence Management
- Post Offer Job Screens
- Ergonomic Assessment
- TMJ / Headaches
- Hand Therapy