



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 _____

Email Address _____ Consent to email? ☐ Yes ☐ No

Age _____ Height _____ Weight _____ Sex: ☐ Male ☐ Female Preferred Pronoun (optional) _____

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: _____



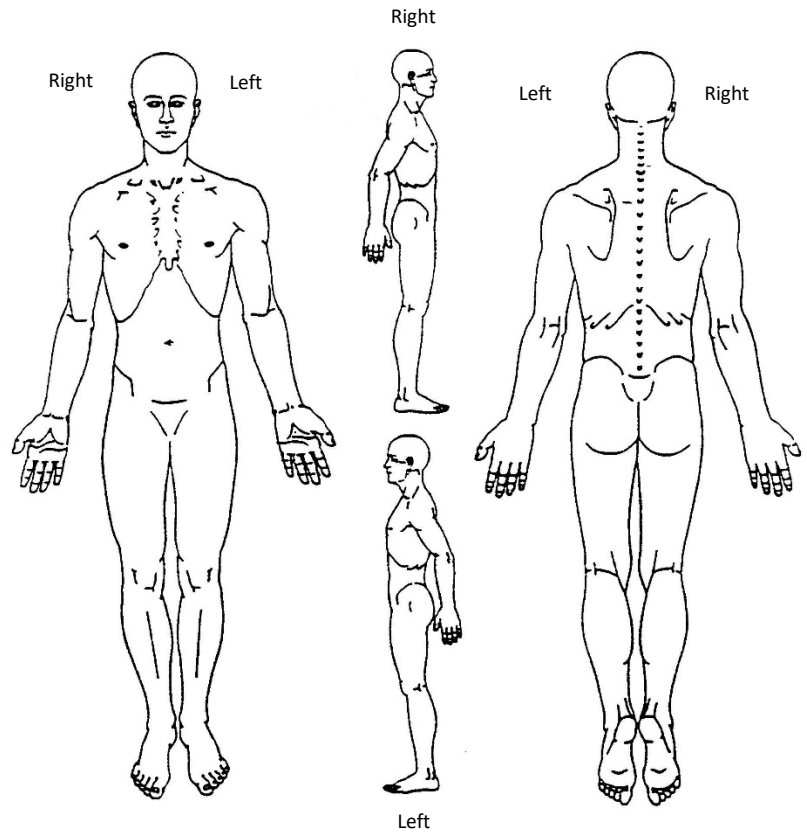
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INJURY / CONDITION INFORMATION (CONTINUED) Please mark/draw on the diagram where you feel symptoms:

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:

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Cancer
<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Hepatitis, TB, HIV, AIDS
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Neurological Disease	<input type="checkbox"/> Smoker
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Seizures	<input type="checkbox"/> COPD/Emphysema
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Anxiety/Panic Issues	<input type="checkbox"/> Current Infection
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Depression	<input type="checkbox"/> Asthma
<input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> Traumatic Brain Injury	<input type="checkbox"/> Allergies
<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Headaches	<input type="checkbox"/> Currently Pregnant
<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____
<input type="checkbox"/> Obesity	<input type="checkbox"/> Diabetes Type I or II	_____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Kidney Issues	_____
<input type="checkbox"/> Osteoporosis (weak bones)	<input type="checkbox"/> 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 to contact 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 CPR Physical Therapy + Performance 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