Staszak Physical Therapy
& Wellness Center

488 E 11th Ave Suite 150A • Eugene, OR 97401
tel: 541.505.8180 • fax: 541.505.7134
staszakpt.com

PATIENT REGISTRATION

PATIENT INFORMATION

Name:_____ Nickname:_____ Date of Birth:_____ Sex: M / F

Mailing Address:_____ City:_____ State:____ Zip Code: _____

Primary Phone #:_____ Secondary Phone#: _____ Email:_____

Referring Physician:_____ Primary Care Physician: _____

How did you hear about us? _____

RESPONSIBLE PARTY INFORMATION *(IF PATIENT IS UNDER 18 YEARS OLD)*

Guarantor Name:_____ Date of Birth:_____ Sex: M / F

Mailing Address:_____ City:_____ State:____ Zip Code: _____

Primary Phone #:_____ Secondary Phone#: _____ Email:_____

Employer Name:_____

I certify that the above information is true and correct to the best of my knowledge. I acknowledge, by signing below, that I accept the terms and agreements stated below. I authorize Staszak Physical Therapy & Wellness Center to contact me via the above listed email for periodic newsletters and promotional specials.

Pricing: The physical therapy evaluation is $140.00 and due at time of service. Follow-up physical therapy visits are $110.00 and due at time of service.

Consent for Treatment and Authorization for Release of Information: I grant permission to the representatives of Staszak Physical Therapy & Wellness Center to perform all necessary procedures and treatments as prescribed by my physician. I understand that I may refuse treatment or terminate services at any time and the clinic may terminate their services to me.

Charge for No Show/Cancellation without 24 hour notice: I understand that Staszak Physical Therapy & Wellness Center has a 24-hour business day policy for cancellations and missed appointments. If I fail to arrive for my scheduled appointment or do not provide the 24-hour business day notice for cancellation of my appointment, I will be charged $50.00. If I am scheduled for both physical therapy and a second service, I will be charged an $80.00 fee. Upon the 3rd violation of this policy, the representatives of Staszak Physical Therapy & Wellness Center reserve the right to charge me the full fee of an appointment, and/or refer me back to my physician, and/or discharge me from their care. Payment for a missed appointment is due upon check in at my next visit.

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Financial Agreement: I understand that there is no guarantee of payment from any insurance company or other payer. Either I do not have personal health insurance coverage, or I am foregoing the option of billing my personal health insurance carrier. I hereby release Staszak Physical Therapy & Wellness Center from billing my personal health insurance carrier for any and all dates of service related to this course of physical therapy treatments. I understand that any payments made to Staszak Physical Therapy & Wellness Center are not credited towards my personal health insurance deductible, and that Staszak Physical Therapy & Wellness Center will not retro-bill previous dates of service. I agree to pre-pay all charges for the services provided by Staszak Physical Therapy & Wellness Center upon check-in to my appointment. I understand that I am responsible for a $35.00 returned check fee in addition to any other associated bank charges.

- I, the patient, can at any time request a copy of this document. I understand that Staszak Physical Therapy & Wellness Center must retain the original, and any photo static copy of this document shall be considered effective and as valid as the original.
- I, the patient, hereby authorize Staszak Physical Therapy & Wellness Center to request and/or receive any and all medical records from my previous physician(s) regarding the treatment I am undergoing at Staszak Physical Therapy & Wellness Center.
- I understand that I have the right to review the Privacy Practices Document which is kept on file at Staszak Physical Therapy & Wellness Center.

By signing below, I confirm that I have read and agree to the above information.

Patient Signature (Age 18 and Over)	Date	Guarantor Signature	Date

Printed Patient Name	Printed Guarantor Name	Relationship to Patient

Updated March 2, 2021

Staszak Physical Therapy And Wellness Center Patient History

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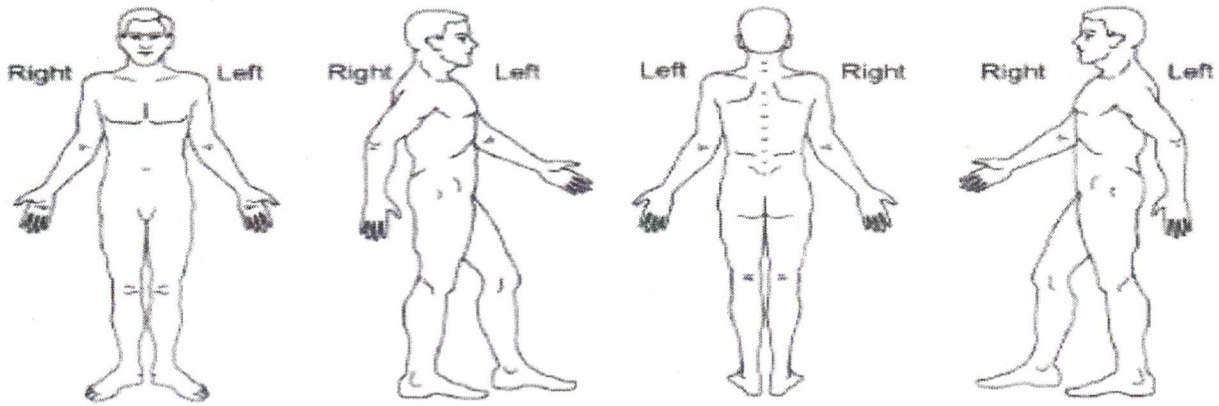
To assist your therapist with the evaluation, please fill out the form below. If you do not understand a question, your therapist will assist you. Thank you for your time.

Today's Date: _____ Name: _____ Date of Birth: _____
Gender Identity: _____ Preferred Pronouns: _____
Next Doctor's Appointment: _____ Employer and Occupation: _____
Presently working? ☐YES ☐NO If no, last day worked? _____
☐Right handed ☐Left handed
What type of problem brings you to the clinic? _____
Injured how? _____ Date of onset: _____
Previous treatment for this condition: _____
Current treatments for current or prior conditions: ☐physical therapy, ☐chiropractic, ☐massage, ☐ other: _____
_____
What are your goals for therapy? _____
Pain Assessment: Describe your pain today: _____
_____
Pain pattern: ☐Constant or ☐Intermittent Pain quality: ☐Sharp ☐Dull ☐Aching ☐Burning

Place a vertical mark on the line below to indicate your least, average and worst pain scores:

0 1 2 3 4 5 6 7 8 9 10
No Pain **Worst Possible Pain**

Shade in the figures below to indicate where your pain is located.



Top 3 Limitations:

Activity	Rating 0 (Unable) to 10 (No Difficulty)
1.	
2.	
3.	

Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada, 47, 258-263.

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LIST OVER-THE-COUNTER and PRESCRIBED medications you are currently using (including pills, injections, and/or skin patches) - please attach or provide list: _____

_____

_____

Have you **EVER** been diagnosed as having any of the following conditions?

Cancer	YES	NO	If **YES**, describe what kind: _____					
Heart problems	YES	NO	Asthma	YES	NO	Fibromyalgia	YES	NO
Pacemaker	YES	NO	Tuberculosis	YES	NO	Thyroid problems	YES	NO
High blood pressure	YES	NO	Emphysema/Bronchitis	YES	NO	Hearing loss	YES	NO
Stroke	YES	NO	Kidney disease	YES	NO	Headaches/Migraines	YES	NO
Neurological disorder	YES	NO	Hepatitis	YES	NO	Epilepsy	YES	NO
Rheumatoid Arthritis	YES	NO	Diabetes	YES	NO	History of MRSA	YES	NO
Other arthritic conditions	YES	NO	Anemia	YES	NO	History of Clostridium	YES	NO
Osteoporosis	YES	NO	Depression	YES	NO	difficile (C-diff)		

Other: _____

Allergies: _____

Previous Diagnostic Tests: ☐X-ray ☐Ultrasound ☐MRI ☐CT scan ☐bone scan Other: _____

List any relevant surgery or injury that you have had:

Date	Injury/Surgery	How was it treated

Do you use:	Tobacco	YES	NO	Caffeine (soda/coffee)	YES	NO
Recently noticed:	Weight loss/gain	YES	NO	Fatigue	YES	NO
	Nausea/Vomiting	YES	NO	Weakness	YES	NO

How do you best learn? ☐Pictures ☐Reading ☐Listening ☐Demonstration
☐Other _____

_____

_____

Therapist's signature Date Time