



## Patient Registration Form – Workers Comp/MVA

|                                                                                                                                                     |  |                                                                         |  |
|-----------------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------------------------------------------------------------|--|
| Patient name:                                                                                                                                       |  | Preferred:                                                              |  |
| Address, City, State, Zip:                                                                                                                          |  |                                                                         |  |
|                                                                                                                                                     |  |                                                                         |  |
| DOB:                                                                                                                                                |  | Social security #:                                                      |  |
|                                                                                                                                                     |  | Email Address:                                                          |  |
| Home Phone:                                                                                                                                         |  | Appointment Reminder Method                                             |  |
| Cell Phone:                                                                                                                                         |  | <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone |  |
| Work Phone:                                                                                                                                         |  | <input type="checkbox"/> Work Phone <input type="checkbox"/> Email      |  |
| Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed |  | Partner's name:                                                         |  |
| Financial Responsibility: <input type="checkbox"/> Self <input type="checkbox"/> Other, please list:                                                |  |                                                                         |  |
| 2nd Contact name/address:                                                                                                                           |  |                                                                         |  |
| 2nd contact phone:                                                                                                                                  |  | Relation:                                                               |  |
| General Physician:                                                                                                                                  |  | Referred by:                                                            |  |

### Insurance Information

**What type of insurance do you plan to bill for these services?** ☐ Auto Insurance ☐ 3rd Party ☐ Worker's Comp  
**In addition to providing the Case Information below** - if billing your Auto Insurance, please also provide your Health insurance carrier information and provide a copy of your insurance card.

|                                                                                                         |                   |                          |
|---------------------------------------------------------------------------------------------------------|-------------------|--------------------------|
| Insurance Carrier:                                                                                      |                   | Group #:                 |
| Name of Insured:                                                                                        |                   | Policy #:                |
| <b>Case Information – work related, MVA, personal injury, complete the below information</b>            |                   |                          |
| <input type="checkbox"/> MVA <input type="checkbox"/> 3 <sup>rd</sup> Party <input type="checkbox"/> WC | Date of Accident: | State Accident Occurred: |
| Name of Employer/Insured:                                                                               |                   | Phone #:                 |
| Address:                                                                                                |                   |                          |
| Claim or Case #:                                                                                        |                   |                          |
| Name of Nurse Case Manager / Adjustor:                                                                  |                   |                          |
| Phone Number for Nurse Case Manager / Adjustor:                                                         |                   | Fax #:                   |
| Do you intend to file liability suit or is litigation pending, if so, please provide Attorney's Name:   |                   | Phone #:                 |

### Consent to Treat/Assignment of Benefits/Acknowledgements

I hereby authorize and consent to treatment/services for myself, or on behalf of the above-named patient performed by the staff at Peak Physical Therapy (Peak) and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the recommended treatment plan.

I assign payment for these services directly to Peak. I authorize the filing of claims to my insurance plan and authorize Peak to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete.

In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believe were covered services, resulting in my responsibility for paying for these services.

I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other permitted uses or disclosures as described in the Notice.

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to the Patient



Patient name:

DOB:

### Authorization for Communication

By providing my above contact information and signing below, I consent and authorize Peak and its related entities, agents, contractors, including but not limited to scheduling, billing, and other departments to use automated telephone dialing systems, SMS text messaging, (if opted in) and electronic mail to (1) provide messages (including prerecorded messages or text messages, (if opted in)) to me about appointment reminders, patient surveys, my account, payment due dates, missed payments, information for or related to medical goods and/or therapy services provided, exchange information, changes to health care law, health care coverage, care follow-up, and other healthcare information or (2) provide messages (including pre-recorded messages) during a call or via text message, (if opted in) that delivers a 'health care' message made by, or on behalf of, a 'covered entity' or its 'business associate' as those terms are defined in the HIPAA Privacy Rule, 45 CFR 160.103. I understand that providing a telephone number and/or email address is not a condition of receiving medical services.

I also understand that I may revoke my consent to contact at any time by directly contacting Peak or using the opt-out method that will be identified in the applicable communication. I also understand that it is my responsibility to notify Peak immediately of any change in telephone number or email address.

### Please check the box below to opt in to receive messaging.

- ☐ **I consent** to receiving text messages about care, appointment reminders, and important health reminders from Peak at the phone number I provided. I acknowledge that my consent is not a condition of purchase. Message & data rates may apply. Message frequency varies. You can reply HELP for support or STOP to opt out of receiving messages. To learn more about how we handle your data please view our privacy policy here.

<https://peakphysicaltherapy.net/wp-content/uploads/sites/7/2026/04/Peak-Physical-Therapy-Website-Privacy-Policy-Terms-11-2025.pdf>

- ☐ **I do not** consent to receiving text messages.

Patient/Guardian Signature:

Date:

### Release of Information

I hereby authorized Peak to discuss my personal healthcare information regarding my treatment including diagnosis/prognosis and/or billing and payment for services rendered on my behalf to the person(s) listed below.

Name (print)

Relationship

Phone number

Name (print)

Relationship

Phone number

Name (print)

Relationship

Phone number

Patient/Guardian Signature:

Date:



**Patient name:**

**DOB:**

**Financial Policy**

**Payment for services is due at the time services are rendered**

We will verify your benefits with your insurance carrier. However, this does not guarantee that they will cover the prescribed treatment. By signing below, you are acknowledging that you are responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance carrier and understand that you are fully responsible for any balance due for services rendered.

Patient/Guardian Signature:

Date:

**Cancellation/No Show Policy and Fee Acknowledgement**

It is the policy of Peak to monitor and manage appointment no-shows and late cancellations. Regular attendance at therapy sessions is crucial for you to recover fully and return to the activities you love. When an appointment is missed, it's a missed opportunity for progress in your recovery, and it impacts our ability to accommodate other patients who may need urgent care.

If you need to cancel or reschedule, please call the clinic.

Scheduled appointments must be cancelled or rescheduled at least 24 hours prior.

Failure to attend your appointment without 24-hour notice may result in a fee of \$50 that will be charged directly to you as the patient (not insurance) for each instance of a missed appointment.

Patient/Guardian Signature:

Date:



|                                                                                                                                                                                                                                 |         |                                                                                      |                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------|--------------------------------------------------------------------|
| <b>Patient name:</b>                                                                                                                                                                                                            |         | <b>DOB:</b>                                                                          |                                                                    |
| <b>PATIENT HEALTH QUESTIONNAIRE</b>                                                                                                                                                                                             |         |                                                                                      |                                                                    |
| Occupation:                                                                                                                                                                                                                     | Height: | Weight:                                                                              | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Leisure activities/hobbies:                                                                                                                                                                                                     |         |                                                                                      |                                                                    |
| Are you? <input type="checkbox"/> Right-handed <input type="checkbox"/> Left-handed                                                                                                                                             |         |                                                                                      |                                                                    |
| Where do you live? <input type="checkbox"/> Private home <input type="checkbox"/> Apartment/rented room <input type="checkbox"/> Assisted living/group home<br><input type="checkbox"/> Hospice <input type="checkbox"/> Other: |         |                                                                                      |                                                                    |
| With whom do you live? <input type="checkbox"/> Alone <input type="checkbox"/> Spouse only <input type="checkbox"/> Spouse and others <input type="checkbox"/> Child<br><input type="checkbox"/> Other:                         |         |                                                                                      |                                                                    |
| Does your home have? <input type="checkbox"/> Stairs, no railing <input type="checkbox"/> Stairs, railing <input type="checkbox"/> Ramps <input type="checkbox"/> Uneven terrain<br>Please explain:                             |         |                                                                                      |                                                                    |
| How many times have you fallen in the past 12 months?                                                                                                                                                                           |         | Did it result in an injury? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                    |
| During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? <input type="checkbox"/> Yes <input type="checkbox"/> No                            |         |                                                                                      |                                                                    |
| General Health Status, please rate your health. <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor                                                    |         |                                                                                      |                                                                    |
| Please list any known allergies (including medications, latex, etc.) below.                                                                                                                                                     |         |                                                                                      |                                                                    |
|                                                                                                                                                                                                                                 |         |                                                                                      |                                                                    |

|                                                                                                                                                                                                                                                                                         |                                                                              |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|
| <b>Social History / Wellness</b>                                                                                                                                                                                                                                                        |                                                                              |
| Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                                                                                              | Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? <input type="checkbox"/> At least 3 times per week <input type="checkbox"/> 1-2 times per week <input type="checkbox"/> Seldom or Never |                                                                              |

|                                                                   |  |
|-------------------------------------------------------------------|--|
| <b>Surgery / Hospitalization, please include date and reason.</b> |  |
|                                                                   |  |
|                                                                   |  |

|                                                                                                                                                      |        |           |                          |
|------------------------------------------------------------------------------------------------------------------------------------------------------|--------|-----------|--------------------------|
| <b>Please list current medications</b> (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy. |        |           |                          |
| Name                                                                                                                                                 | Dosage | Frequency | Please indicate route    |
|                                                                                                                                                      |        |           | Oral Patch Topical Other |
|                                                                                                                                                      |        |           | Oral Patch Topical Other |
|                                                                                                                                                      |        |           | Oral Patch Topical Other |
|                                                                                                                                                      |        |           | Oral Patch Topical Other |

|                                                             |                                                          |                              |                                                          |
|-------------------------------------------------------------|----------------------------------------------------------|------------------------------|----------------------------------------------------------|
| <b>Are you currently experiencing any of the following?</b> |                                                          |                              |                                                          |
| Nausea or vomiting                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chest Pains (Angina)         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Productive/chronic cough                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain wakes me at night       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty Swallowing                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Recent fever, chills, sweats | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dizzy Spells                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty sleeping          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Headaches                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of breath          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Visual problems                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart palpitations           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hearing loss/ringing in ears                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Loss of appetite             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Difficulty walking                                          | <input type="checkbox"/> Yes <input type="checkbox"/> No | Incontinence                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Unusual weakness                                            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Fatigue or myalgia           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Joint pain or swelling                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unexplained weight changes   | <input type="checkbox"/> Yes <input type="checkbox"/> No |

|                                                           |                                                          |                             |                                                          |
|-----------------------------------------------------------|----------------------------------------------------------|-----------------------------|----------------------------------------------------------|
| <b>Patient name:</b>                                      |                                                          | <b>DOB:</b>                 |                                                          |
| <b>Have you been diagnosed with any of the following?</b> |                                                          |                             |                                                          |
| Allergies                                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hearing Loss                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia                                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alzheimer's                                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | HIV                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis, If Yes, Type:                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Respiratory Problems                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease/Problems     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Auto Immune Disease<br>If yes, Type:                      | <input type="checkbox"/> Yes <input type="checkbox"/> No | Spinal Cord Stimulator      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Clots                                               | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vision Problems             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bowel or Bladder Disorder                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteopenia/Osteoporosis     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer, If yes, Site:                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Conditions                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cardiac Pacemaker                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No | Peripheral Vascular Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Currently Pregnant                                        | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dementia                                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke/TIA                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Depression                                                | <input type="checkbox"/> Yes <input type="checkbox"/> No | Speech Problems             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes                                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No | Other:                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Fractures                                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | List                        |                                                          |

|                                                                                                                                                                                                                 |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Current Condition</b>                                                                                                                                                                                        |
| When did this problem(s) first begin/date of onset?                                                                                                                                                             |
| If chronic, when did you seek medical treatment?                                                                                                                                                                |
| Is your current condition related to recent surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, specify date of surgery:                                                                  |
| Describe the problem(s).                                                                                                                                                                                        |
|                                                                                                                                                                                                                 |
| Explain how problem(s) occurred.                                                                                                                                                                                |
|                                                                                                                                                                                                                 |
|                                                                                                                                                                                                                 |
| Have you ever had this problem before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times?                                                                                         |
| Are your symptoms worse in the: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> Same All Day       |
| How are you taking care of the problem(s) now?                                                                                                                                                                  |
| My pain/problem is slowing getting: <input type="checkbox"/> Worse <input type="checkbox"/> Better <input type="checkbox"/> Staying the Same                                                                    |
| My symptoms bother me: <input type="checkbox"/> Constantly (100%) <input type="checkbox"/> Most of the Time (75%)<br><input type="checkbox"/> Occasionally (50%) <input type="checkbox"/> Once in a While (25%) |
| Do you have any numbness, tingling, or burning? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                        |
| If yes, please check one: <input type="checkbox"/> Constantly <input type="checkbox"/> Intermittently                                                                                                           |
| What functions could you perform before, that you now are unable to do?                                                                                                                                         |
|                                                                                                                                                                                                                 |
| Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.                                        |
|                                                                                                                                                                                                                 |
| Have you received X-rays, MRI, CT scan, Bone scan for this problem? If so, please list the dates and results.                                                                                                   |
|                                                                                                                                                                                                                 |
| Are you aware of any physical reason why you should not receive treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                             |
| If yes, please tell us what it is:                                                                                                                                                                              |
| What are your goals for therapy?                                                                                                                                                                                |

**Patient name:**

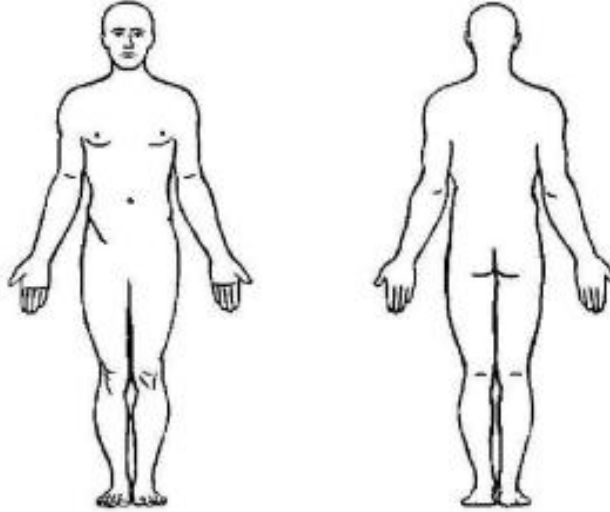
**DOB:**

**Symptom Rating**

Mark on the body diagram the location of symptom(s):

O - For pain

X - For numbness/tingling/burning

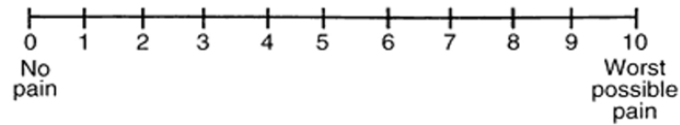


**Please rate your pain on a scale from 0 – 10 (0 = no pain; 10 = Worst pain imaginable)**

Current:     /10

Best:       /10

Worst:     /10



**I will advise the therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_