Office Use Only - P#: _____

ILLINOIS BONE & JOINT INSTITUTE®
Move better. Live better.

# REHABILITATION SERVICES - REGISTRATION FORM

Date of Birth: _____ / _____ / _____ Cell Phone #: _____ Email: _____

*Your email will only be used to communicate with you about your care, account, IBJI Service surveys, or education. I understand that if information is emailed to me, there may be some level of risk that this information could be read by an unauthorized party. By providing my email address, I am accepting the risks and authorizing IBJI, its physicians and staff to communicate with me electronically about my care, account, IBJI service surveys, IBJI products and services, and/or education.*

*24 hour notice for cancellation required. Failure to comply may result in a $20 cancellation/no show charge.* X_____ (Initial here)

| | | |
|---|---|---|
| Have you had physical or occupational therapy elsewhere this year? | ☐ **Yes** | ☐ **No** |
| If so, was it for the same injury or diagnosis as your current appointments? | ☐ **Yes** | ☐ **No** |
| Are you currently receiving home health care? | ☐ **Yes** | ☐ **No** |
| Are you residing in a medical nursing facility either temporarily or permanently? | ☐ **Yes** | ☐ **No** |
| Is your injury work related? | ☐ **Yes** | ☐ **No** |

MEDICAL HISTORY Please check any conditions that apply to you:

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Cancer
- ☐ Cardiac Conditions
- ☐ Cardiac Pacemaker
- ☐ Chemical Dependency
- ☐ Circulation Problems
- ☐ Currently Pregnant
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Emphysema/Bronchitis
- ☐ Fibromyalgia
- ☐ Fractures
- ☐ Gallbladder Problems
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ High/Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Incontinence
- ☐ Kidney Problems
- ☐ Metal Implants
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Muscular Disease
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Smoking
- ☐ Speech Problems
- ☐ Strokes
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vision Problems

Describe any other conditions (including any known drug allergies): _____

_____

_____

| | | |
|---|---|---|
| Have you been injured as a result of a fall in the past year? | ☐ Yes | ☐ No |
| Have you had two or more falls in the last year? | ☐ Yes | ☐ No |

List any surgeries and year of the surgery (if applicable): _____

_____

Please list medications and dosages or provide a medication list with dosages if applicable: _____

_____

**Patient Signature/Authorized Representative:** _____ **Date:** _____ / _____ / _____

**Patient Printed Name/Authorized Representative:** _____ **Relationship:** _____