Cardinal Hill Rehabilitation Hospital
Center for Outpatient Therapy Services

Registration Form

Client Name: _______________________________________ Client ID: __________________ Date: ___________________

Please check the boxes that indicate the reason for this visit:

Is this visit related to a problem at birth? ☐Yes ☐ No

If yes please describe: ____

Were you involved in an accident? ☐Yes ☐No If yes, date of accident? __________________________________

Type of accident (auto, sports, fall, work, other): ____

If a fall, did you fall somewhere other than your home? ☐Yes ☐No If yes, where? _____________________________

If yes, who is the homeowner or liability insurance carrier? ___________________________________Phone: ___________

If an auto accident, what state did it happen in? _______ Auto Ins: ____

Adjustor: _________________Auto Insurance Claim Number: ___________________________ Phone: __________________

Name of Attorney, if applicable: ____ Phone: __________________

If work injury, name of Worker's Comp: ____Phone: __________________

Worker's Comp. Claim Number: ____

Is your visit related to an illness? ☐Yes ☐ No Date illness began: _____________________________________

Or date that symptoms began / got worse: ____

Is your visit surgery related? ☐Yes ☐ No Date of surgery: ____

Have you ever received Home Health Services? ☐Yes ☐ No

If yes, when: ____________________________________ Type of Services: ____

Name of Home Health Agency: ____ Phone: _________________________

Have you received therapy services before? ☐Yes ☐ No

If yes, when: ________________________________ Type of therapy received: _____________________________________

Name of Agency: ____Phone: __________________________

Have you ever received the services of a chiropractor? ☐Yes ☐ No If yes, when? _______________________

Where? ____ Phone: _________________________