



Patient Registration Form

Date: _____ Home Phone: (_____) _____

General Patient Information

Patient's Name: _____
(Last) (First) (MI)

Birthdate: ____ / ____ / ____ Sex: M F Marital Status: M S D W Smoker Non-Smoker

Address: _____ City: _____

State: _____ Zip: _____ E-mail Address: _____

Soc. Sec. # _____ - _____ - _____

Employer: _____ Work #: (_____) Ext: _____

Primary Care Provider: _____ Referred by: _____

Insurance Information

Primary Insurance Co: _____ Policy # _____

Insured Name: _____ Soc. Sec. # _____ - _____ - _____

Secondary Insurance Co: _____ Policy # _____

Insured Name: _____ Soc. Sec. # _____ - _____ - _____

Attorney's Name: _____ Attorney's Phone: _____

Medical Information

List any medications you are taking: _____

List any allergies you may have: _____

List any prior surgeries: _____

Do you have any of the following?

	Now	Past		Now	Past
Dizziness			Chest Pain		
Stroke			Irregular Heartbeat		
Arthritis			High Blood Pressure		
Asthma			Cancer		
Diabetes			Shortness of Breath		
Pacemaker			Heart Disease		
TB			HIV		
HEP C			HEP B		



Condition/Injury Information

Name: _____

Reason for seeking physical therapy services: _____

Date pain or problem began: _____

Is this visit because of an injury? YES NO

How did this injury occur? Work Auto Accident Home Recreation Other

a. Have you ever been injured or suffered previous pains/problems in the area(s) before this injury?

YES NO If yes, when? _____

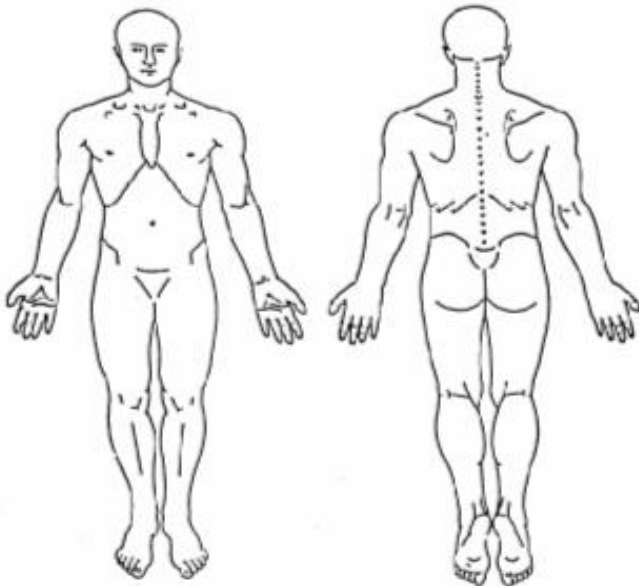
b. Have you had a recent X-ray, CT or MRI of the injured area? YES NO

When? _____ Where? _____

c. Did you recover from this injury? YES NO

From the list below, please check those activities that you are either unable to perform in a normal fashion or have difficulty performing because of your pain/problem.

	<u>Difficult</u>	<u>Unable</u>		<u>Difficult</u>	<u>Unable</u>
Sit	()	()	Housework	()	()
Stand	()	()	Yard Work	()	()
Walk	()	()	Twist	()	()
Push	()	()	Bend	()	()
Pull	()	()	Squat	()	()
Lift	()	()	Drive	()	()
Stretch	()	()	Ride in a Car	()	()
Climb	()	()			



Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain not related to your present injury or condition.

/// : Stabbing

XXX : Burning

OOO : Pins & Needles

=== : Numbness

+++ : Achey

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