Patient Registration Form
(please print)

Date of Injury or Onset:_________________________

Last Name	First Name	M.I.	Preferred Name:
Address	City	State	Zip
Home Phone	Cell/Other	Work Phone	Soc. Security #
Drivers' License	Date of Birth	Age	Sex	Marital Status	Spouses Name
Employer	Occupation	Address	City, Zip
Email:			

Have you had physical therapy during this year?	**If yes, how many visits ?**
Is this visit a result of work injury ? Yes ________ No __________	Date Injured ? _____________________________________
Is this a result of a car accident ? Yes ________ No __________	Date of Accident? Lien? Attorney Name
How did you hear about us?	**Who can we thank for referring you to us?**

Emergency Contact

Last Name	First Name	M.I.	Preferred Name
Address	City	State	Zip
Home Phone	Work Phone	Relationship to Patient	
Employer	Address	City, State, Zip	

ALL CASH PATIENTS AND PATIENTS WITH CO-PAY AMOUNTS MUST PAY AT TIME SERVICE IS RENDERED

Responsible Party (if other than patient)

Last Name	First Name	M.I.	
Address	City	State	Zip
Home Phone	Work Phone	Soc. Security #	
Employer	Address	City, State, Zip	

Signature / Authorization of responsible party accepting liability: ____

Verified by:____ **Date:** ________________________

Continued on reverse

Medical Questionnaire **Name:**______________________________ **Date:**___________

Age:__________ **Height:**__________ **Weight:**_________ lbs. **Blood Pressure:**___________

Heart Rate:_______ **O_2 Saturation:**____________

Leisure activities, including exercise routines: ____

Occupation, including activities that comprise your workday: ____

Are you on a work restriction from your doctor? *YES* *NO* **Are you latex sensitive?** *YES* *NO*

Do you smoke? *YES* *NO* **Do you have a pacemaker?** *YES* *NO*

WOMEN: Are you currently or think you might be pregnant? *YES* *NO*

ALLERGIES: List any medication(s) you are allergic to:

____

Have you RECENTLY noted any of the following (check all that apply)?

- ☐ Fatigue
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Weight loss/gain
- ☐ Difficulty maintaining balance while walking
- ☐ Changes in bowel or bladder function
- ☐ Falls
- ☐ Numbness or tingling
- ☐ Muscle weakness
- ☐ Dizziness/lightheadedness
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Constipation
- ☐ Diarrhea
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cough
- ☐ Headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Bone or joint infection
- ☐ Chemical dependency (i.e. alcoholism)
- ☐ Depression
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Rheumatoid arthritis
- ☐ Other arthritic condition
- ☐ Bladder/urinary tract infection
- ☐ Kidney problem/infection
- ☐ Sexually transmitted disease/HIV
- ☐ Pelvic inflammatory disease
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Eye problem/infection
- ☐ Ulcers
- ☐ Liver problems
- ☐ Hepatitis
- ☐ Pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Depression
- ☐ Stroke
- ☐ Blood clots
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Tuberculosis
- ☐ Thyroid problems

____

During the past month have you been feeling down, depressed, or hopeless? *YES* *NO*

During the past month have you been bothered by having little interest or pleasure in doing things? *YES* *NO*

Is this something with which you would like help? *YES* *YES, BUT NOT TODAY* *NO*

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? *YES* *NO*

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1.______________________ 2.____________________________ 3.__________ _______________ 4. _______________________

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? *YES* *NO*

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? *YES* *NO*

Have you ever taken steroid medications for any medical conditions? *YES* *NO*

Therapist Signature: ____________________________ J. Scott Plank, PT, MS, DPT, ATC, CSCS Date:____________

Medical Questionnaire **Name:**______________________________ **Date:**___________

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1.________________________ 2.___________________________ 3.________________________ 4. _______________________

What date (roughly) did your present symptoms start? ______________________

What do you think caused your symptoms? ____

My symptoms are currently: ☐ *GETTING BETTER* ☐ *GETTING WORSE* ☐ *STAYING ABOUT THE SAME*

I should not do physical activities that might make my pain worse: ☐ *DISAGREE* ☐ *UNSURE* ☐ *AGREE*

Do you expect to return to the activity levels you were at prior to developing these symptoms? *YES* *NO*

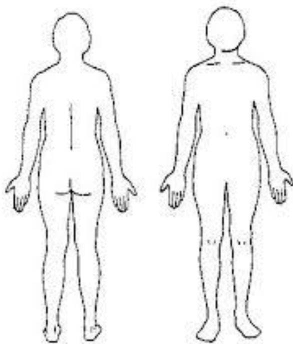
Have you ever had this problem before? *YES* *NO*

If so when, and what treatment was received? ____

How long did it take for you to feel better? ____

____

BODY CHART:
Please mark the areas where you feel symptoms on the chart below with the following symbols to describe your symptoms:



→ Shooting/sharp pain
O Dull/aching pain
≡ Numbness
= Tingling

My symptoms currently:

☐COME AND GO ☐ ARE CONSTANT ☐ ARE CONSTANT, BUT CHANGE WITH ACTIVITY

____

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1.________________________________ 2._____________________________________ 3.__________________________________

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
1.________________________________ 2._____________________________________ 3.__________________________________

How are you currently able to sleep at night due to your symptoms?

☐ NO PROBLEM SLEEPING ☐ DIFFICULTY FALLING ASLEEP ☐AWAKENED BY PAIN ☐SLEEP ONLY WITH MEDICATION

When are your symptoms worst?

☐MORNING ☐AFTERNOON ☐ EVENING ☐ NIGHT ☐ AFTER EXERCISE

When are your symptoms the best?

☐MORNING ☐AFTERNOON ☐ EVENING ☐ NIGHT ☐ AFTER EXERCISE

____

Using the 0 to 10 scale, with 0 being "no pain" and 10 being "worst pain imaginable" please describe:

Your current level of pain while completing this survey: _______

The best your pain has been during the past 24 hours: _______

The worst your pain has been during the past 24 hours: _______