



Patient Registration

Date: _____

#1 WC #2 No Ins #3 Ins/PPO #4 Medicaid #5 Medicare #6 HMO #7MVA #8 BCBS #9 Providence

Name: (Last) _____ (First) _____ (Mid Int) _____

Address: _____ Email: _____

City _____ St _____ Zip _____ Male Female

Home Phone () _____ Cell Phone () _____

DOB: ____/____/____ SS# _____ - _____ - _____ Marital Status: M S D W

Drivers License Number: _____ Parents Name (only if Minor): _____

Employer: _____ Occupation: _____

Work Telephone () _____ Employer's Address: _____

Referring Physician: _____ Phone #: _____

Diagnosis: _____ ICD _____ Rx Visits/Duration: _____

Date of First Appointment: _____

Therapist: _____

Emergency Contact Person: _____ Telephone: () _____

Relationship: _____ Work Phone: () _____

PRIVATE HEALTH INSURANCE (please show cards to Office Manager)

Primary Insurance: _____ Telephone : () _____

Policy/Claim #: _____ Group #: _____ Group Name _____

Insured Name: Self Other: _____ Relationship: _____ DOB: _____

Secondary Insurance: _____ Telephone : () _____

Policy/Claim #: _____ Group #: _____ Group Name _____

Insured Name: Self Other: _____ Relationship: _____ DOB: _____

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION:

Date of Accident: _____ How did it happen? Auto Work Other (location) _____

Attorney's Name/Address/Phone _____

Insurance Company (worker's comp or your auto PIP): _____

Address: _____ Phone #: _____

Claim #: _____ Adjuster: _____

Name of insured: _____

MCO: _____ Auth Required: Yes No

Employer at the time of injury: _____ Phone: _____

How did you hear about us? Family/Friend Doctor Insurance Phone Book Other _____

PATIENT MEDICAL HISTORY

Name: _____ Physician: _____

Please list any surgeries you have had for this injury: _____

Please list any medications for this injury: _____

Are you allergic to any medications? Yes No List Medications: _____

Have you had any of the following Medical or Rehabilitative Services for *this* Injury/ Episode?

- | | |
|---|---|
| <input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Occupational Therapy
<input type="checkbox"/> Chiropractic
<input type="checkbox"/> Emergency Room Care
<input type="checkbox"/> Massage Therapy
<input type="checkbox"/> Acupuncture | <input type="checkbox"/> X-Rays
<input type="checkbox"/> CT Scan
<input type="checkbox"/> MRI
<input type="checkbox"/> Bone Scan |
|---|---|

Do you have or have you *ever* had any of the following?

- | | |
|---|---|
| <input type="checkbox"/> Asthma, Bronchitis, or Emphysema
<input type="checkbox"/> Shortness of Breath/ Chest Pain
<input type="checkbox"/> Coronary Heart Disease or Angina
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Heart Attack or Heart Surgery
<input type="checkbox"/> Stroke
<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Blood Clot/ Emboli
<input type="checkbox"/> Epilepsy/ Seizures
<input type="checkbox"/> Thyroid Disease or Goiter
<input type="checkbox"/> Anemia
<input type="checkbox"/> Infectious Disease
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Cancer
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Gout
<input type="checkbox"/> Sleeping Problems
<input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Severe or Frequent Headaches
<input type="checkbox"/> Visual or Hearing Difficulties
<input type="checkbox"/> Dizziness or Fainting
<input type="checkbox"/> Bowel or Bladder Problems
<input type="checkbox"/> Weakness
<input type="checkbox"/> Weight Loss/ Energy Loss
<input type="checkbox"/> Hernia
<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Allergies
<input type="checkbox"/> Any Pins or Metal Implants
<input type="checkbox"/> Neck Injury or Surgery
<input type="checkbox"/> Joint Replacement Surgery
<input type="checkbox"/> Shoulder Injury or Surgery
<input type="checkbox"/> Elbow/Hand Injury or Surgery
<input type="checkbox"/> Back Injury or Surgery
<input type="checkbox"/> Knee Injury or Surgery
<input type="checkbox"/> Leg/Ankle Injury or Surgery
<input type="checkbox"/> Are Pregnant/ Trying
<input type="checkbox"/> Use Tobacco |
|---|---|

ONLY MEDICARE PATIENTS:

Date last seen by your physician: ____ / ____ / ____

Please list any other information that you believe would assist the therapist in your care:

Are you aware of your diagnosis and prognosis as explained by your doctor? Yes No

What are your rehabilitation expectations and goals while in the program? _____

Patient / Guardian Signature: _____ **Date:** _____