



Patient Registration Form

Date: _____

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext _____

Cell Phone _____ Email _____

SSN _____ DOB _____ Sex _____

How did you hear of us? _____

Employment Status: _____ Employer Name _____

Marital Status: _____ Referring Doctor _____ Date of last visit _____

Emergency Contact _____ Phone _____

Financial Responsibility Name _____

Financial Responsibility Address _____

Is this related to a Motor Vehicle Accident? Y or N, Date of Injury _____ State _____

Is this related to a Workers Compensation Claim? Y or N, Date of Injury _____ Surgery Date _____

MVA/Worker Comp Carrier (if applicable) _____

Claim Number _____

Adjuster's Name _____ Phone _____

Private Primary Health Insurance _____

ID Number _____ Group Number _____

Relationship to Insured: (please circle) Self Spouse Child Other _____

Subscribers Name/Address _____ DOB _____ Sex _____

Private Secondary Health Insurance _____

ID Number _____ Group Number _____

Relationship to Insured: (please circle) Self Spouse Child Other _____

Subscribers Name/Address _____ DOB _____ Sex _____

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

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

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

ALL 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: _____