REGISTRATION FORM

Name _____ Date _____
Last **First** **MI**

Mailing Address _____
Street **City** **State** **Zip Code**

Physical Address _____
Street **City** **State** **Zip Code**

Home Phone **w/area code** _____ Work Phone _____ Cell Phone _____

Contact Preference: ☐ Home ☐ Work ☐ Cell E-mail Address _____

Social Security Number _____ Birth date _____ Sex: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner; Registered in: _____ Spouse/Partner's Name _____ ☐ Divorced ☐ Widowed

Employer _____ Employer's Address _____

Primary Care Physician _____ Referring Physician _____

Emergency Contact _____ Relationship _____

Home Phone **w/area code** _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION – PLEASE GIVE YOUR CARDS TO THE FRONT DESK FOR SCANNING

Primary Insurance _____

Subscriber's Name _____ Birth date _____

ID Number _____ Group Number _____

Secondary Insurance _____

Subscriber's Name _____ Birth date _____

ID Number _____ Group Number _____

IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of accident _____ How did it happen? ☐ Auto ☐ Work ☐ Other State in which injury occurred _____

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

Address _____ Claims Adjuster _____ Phone number _____

I verify that the above information is accurate (Signature) _____

(Date) _____

PATIENT QUESTIONNAIRE / HEALTH HISTORY

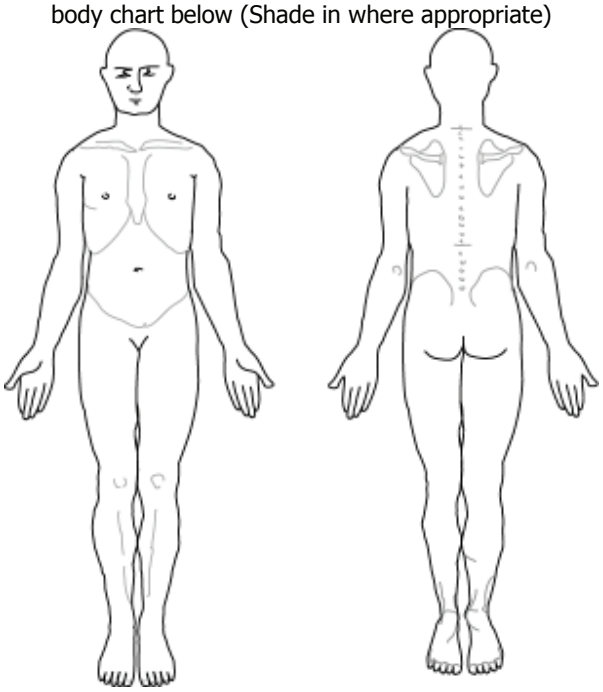
NAME: _____ **DATE:** _____

To insure you receive a complete and thorough evaluation. please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

1. What are your symptoms? _____
_____
_____

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)



2. When did your symptoms begin?
(Please indicate a specific date if possible)_____

3. Was the **onset** of this episode gradual or sudden?(Check one)
❒ (1) gradual ❒ (2) sudden

4. Which of the following **best describes** how your injury occurred? (if your condition is post-surgical please indicate as per original injury)
❒ (1) lifting
❒ (2) a MVA (car accident
❒ (3) a fall
❒ (4) overuse (cumulative trauma)
❒ (5) trauma
❒ (6) degenerative process
❒ (7) during recreation/sports
❒ (8) running
❒ (9) a blow to the face
❒ (10) being hit by a ball
❒ (11) a dental appointment
❒ (12) throwing
❒ (13) an incident at work
❒ (14) unknown
❒ (15) other _____

5. Since onset, are your symptoms getting: (Check one)
❒ (1) better ❒ (2) worse ❒ (3) not changing

6. Have you had similar symptoms in the past? (1)❒ Yes (2) ❒ No
More than one episode? (1) ❒ Yes (2) ❒ No

7. Nature of pain/symptoms (check all that apply)
❒ (1) sharp ❒ (4) aching ❒ (7) constant
❒ (2) dull ❒ (5) periodic ❒ (8) other _____
❒ (3) throbbing ❒ (6) occasional _____

8. As the day progresses, do your symptoms: (Check one)
❒ (1) increase ❒ (2) decrease ❒ (3) stay the same

9. Does the pain wake you at night? ❒ (1) No ❒ (2) Yes
if "*yes*", is it present ❒ (1) while lying still
❒ (2) only when changing positions
❒ (3) both

10. Do you have pain/stiffness upon getting out of bed in the morning? ❒ (1) Yes ❒ (2) No

11. In what position do you sleep? (Check all that apply)
❒ (1) right side ❒ (4) back ❒ (6) back, sides, stomach
❒ (2) left side ❒ (5) chair/recliner ❒ (7) other _____
❒ (3) stomach

12. Since the onset of your current symptoms have you had:
❒ (1) any difficulty with control of bowel or bladder function
❒ (2) fever/Chills
❒ (3) any numbness in the genital or anal area
❒ (4) numbness
❒ (5) any dizziness or fainting attacks
❒ (6) weakness
❒ (7) unexplained weight change
❒ (8) night pain/sweats
❒ (9) malaise (vague feeling of bodily discomfort)
❒ (10) problems with vision/hearing
❒ (11) none of the above

13. What aggravates your symptoms? (Check all that apply)
❒ (1) sitting
❒ (2) going to/rising from sitting
❒ (3) lying down
❒ (4) walking
❒ (5) up/down stairs
❒ (6) reaching overhead
❒ (6) reaching in front of body
❒ (6) reaching behind back
❒ (6) reaching across body
❒ (7) talking, chewing, yawning, all (*circle one*)
❒ (8) recreation/sports including _____
❒ (9) repetitive activities including _____
❒ (10) household activities including _____
❒ (11) standing
❒ (12) squatting
❒ (13) sleeping
❒ (14) coughing/sneezing
❒ (15) taking a deep breath
❒ (16) looking up overhead
❒ (17) swallowing
❒ (18) stress
❒ (19) sustained bending
❒ (20) other _____

14. What relieves your symptoms? (Check all that apply)
❒ (1) sitting ❒ (6) rest ❒ (11) massage
❒ (2) heat ❒ (7) standing ❒ (12) medication
❒ (3) cold ❒ (8) walking ❒ (13) nothing
❒ (4) stretching ❒ (9) exercise ❒ (14) other_____
❒ (5) wearing a splint/orthosis ❒ (10) lying down _____

15. Have you had any previous treatment for this condition? (Check all that apply)

- ❒ (1) none
- ❒ (2) medication (oral)
- ❒ (3) joint manipulation
- ❒ (4) exercise
- ❒ (5) massage therapy
- ❒ (6) traction
- ❒ (7) bracing/taping
- ❒ (8) injection into the spine
- ❒ (9) injection into the skin/muscles
- ❒ (10) physical therapy
- ❒ (11) hypnosis
- ❒ (12) biofeedback
- ❒ (13) TENS unit
- ❒ (14) acupuncture
- ❒ (15) bed rest
- ❒ (16) overnight hospitalization
- ❒ (17) casting
- ❒ (18) other_____

16. Have you had any of the following tests?

- ❒ (1) none
- ❒ (2) x-rays
- ❒ (3) CT Scan
- ❒ (4) MRI
- ❒ (5) Arthrogram
- ❒ (6) Stress X-ray Test (Telos)
- ❒ (7) Bone Scan
- ❒ (8) NCS
- ❒ (9) Fluoroscope
- ❒ (10) Vestibular
- ❒ (11) other_____

Test Results:_____

MEDICATION

Please list any prescription medications you are currently taking (*pain pills, injections and/or skin patches, etc.*):

_____

_____

Prescribing MD:_____Phone:_____

Are you currently taking any of the following over the counter medications?

- ❒ (1) aspirin
- ❒ (2) Tylenol
- ❒ (3) corticosteroids
- ❒ (4) antihistamines
- ❒ (5) vitamins/mineral supplements
- ❒ (6) Advil/Motrin/ Ibuprofen
- ❒ (7) other_____

PREVIOUS FUNCTIONAL LEVEL

❒ **Independent in all activities** (work, community, home, recreation)

Self-care

- ❒ Independent in all self-care activities (bathing, toileting, dressing, etc.)
- ❒ Difficulty performing self-care activities
- ❒ Need assistance with self-care activities
- ❒ Difficulty performing household chores

Social

- ❒ Need assistance with activities in community outside of home

Hobbies:_____

WORK HISTORY

Occupation_____

- ❒ (1) employed full time
- ❒ (2) employed part time
- ❒ (3) self employed
- ❒ (4) homemaker
- ❒ (5) student
- ❒ (6) retired
- ❒ (7) unemployed
- ❒ (8) other_____

Physical activities at work (check all that apply)

- ❒ (1) sitting
- ❒ (2) standing
- ❒ (3) phone use
- ❒ (4) repetitive lifting
- ❒ (5) heavy lifting
- ❒ (6) computer use
- ❒ (7) heavy equipment operation
- ❒ (8) driving
- ❒ (9) other_____

Are you currently receiving or seeking disability for this condition? ❒ (1) Yes ❒ (2) No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

❒ (1) Yes ❒ (2) No

LIVING SITUATION

- ❒ (1) live alone
- ❒ (2) live with family members/others
- ❒ (3) live with caregiver
- ❒ (4) home/apartment
- ❒ (5) retirement complex (SNF/ICF)
- ❒ (6) assisted living complex
- ❒ (7) other_____

Setting

- ❒ (1) stairs (railing)
- ❒ (2) stairs (no railing)
- ❒ (3) no stairs
- ❒ (4) ramp
- ❒ (5) elevator
- ❒ (6) uneven ground
- ❒ (7) other_____

GENERAL HEALTH

How would you rate your general health?

❒ Excellent ❒ Good ❒ Average ❒ Fair ❒ Poor

Do you exercise outside of normal daily activities?

❒ 5+ days/wk ❒ 3-4 days/wk ❒ 1-2 days/wk ❒ occasionally ❒ zero

Exercise, Sports/Recreation consisting of _____

_____

Do you drink caffeinated beverages?

❒ No ❒ Yes How many/much per day_____

Do you smoke?

❒ No ❒ Yes Packs of cigarettes per day_____

What is your stress level?

❒ Low ❒ Medium ❒ High

Are you seeing any health care providers other than the physical therapist for this current condition? (Please list)_____

_____

_____

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

- ❒ Cancer (type)_____
- ❒ Depression
- ❒ Stroke
- ❒ Kidney problems
- ❒ Thyroid problems
- ❒ Diabetes
- ❒ Multiple sclerosis
- ❒ Arthritis
- ❒ Head injury
- ❒ Stomach problems
- ❒ Parkinson's disease
- ❒ Infectious diseases (i.e. hepatitis, tuberculosis, etc.)
- ❒ Heart problems
- ❒ High blood pressure
- ❒ Lung problems
- ❒ Blood disorders
- ❒ Epilepsy/seizures
- ❒ Allergies
- ❒ Rheumatoid arthritis
- ❒ Osteoporosis
- ❒ Broken bone
- ❒ Circulation/vascular problems
- ❒ Other_____

Please list any recent/relevant past surgeries related to your current problem:

SURGERY **DATE**

_____

_____

_____

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated of any of the following?

- ❒ Diabetes
- ❒ Heart disease
- ❒ High blood pressure
- ❒ Stroke
- ❒ Other_____
- ❒ Cancer
- ❒ Arthritis
- ❒ Osteoporosis
- ❒ Psychological condition