TherapeuticAssociates
PHYSICAL THERAPY

PATIENT REGISTRATION

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) _____

Please tell us how you learned of our service or whom we can thank

☐ I was a **Former Patient**
☐ **Former Patient** recommendation
☐ **Health Club/Professional** recommendation
☐ **Family/Friend/Co-Worker** recommendation
☐ **Doctor** recommendation
☐ **Radio** advertisement
☐ **Yellow Page** advertisement
☐ Found you on the **Internet**
Website: _____
☐ **TV/Billboard** advertisement
☐ **Publication/Newspaper** advertisement
Publication: _____
☐ **Clinic Sign**
☐ Saw you at an **Event**
Event: _____

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To save time in your registration process, please fill out and print this form and bring it with you to the clinic for your appointment. If unable, you will be able to fill out the form when you arrive for your appointment.

NAME:_____ DATE:_____

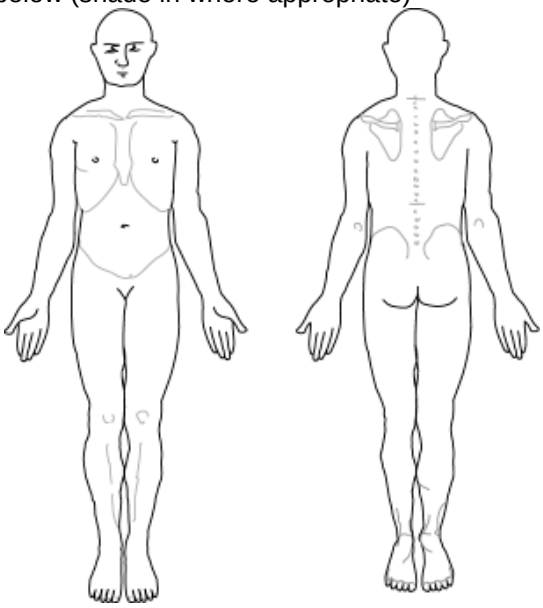
HISTORY OF PRESENT CONDITION

To insure that 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.

1) Reason for visit? _____

_____

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/timing** of this episode?
❒ gradual ❒ sudden
Any previous episodes ❒ Yes ❒ No

4) Which of the following best describes how your injury occurred? *(If you condition is post-surgical, please indicate as per original injury)*
❒ unknown ❒ degenerative process
❒ while Lifting ❒ an incident at work
❒ MVA (car accident) ❒ dental appointment
❒ a fall ❒ during recreation/sports
❒ trauma ❒ overuse (cumulative trauma)
❒ other_____

5) Since the onset, are your symptoms? (Check one)
❒ improving ❒ not changing ❒ worsening

6) Have you had any fall(s) in the past year? ❒ No
❒ Yes, how many times _____ ; ❒ injured ❒ not injured

7) Nature of pain/symptoms (check all that apply)
❒ sharp ❒ aching ❒ constant
❒ dull ❒ periodic ❒ other_____
❒ throbbing ❒ occasional

As the day progresses, do your symptoms: (Check one)
❒ increase ❒ decrease ❒ stay the same

Does the pain wake you at night?
❒ No ❒ Yes If "yes", is it present
❒ while lying down ❒ only when changing positions
❒ both

Do you have pain/stiffness upon getting out of bed in the morning? ❒ Yes ❒ No

8) In what position do you sleep? (Check all that apply)
❒ back, sides, stomach ❒ right side
❒ left side ❒ on stomach
❒ on back ❒ chair/recliner

9) Since the onset of your current symptoms have you had: (Check all that apply)
❒ any difficulty with bowel or bladder function
❒ fever/chills
❒ numbness in the genitals or anal area
❒ numbness
❒ any dizziness or fainting
❒ unexplained weakness
❒ unexplained weight change
❒ night pain/sweats
❒ malaise (vague feeling of bodily discomfort
❒ problems with vision/hearing
❒ none of the above

10) What aggravates your symptoms? (Check all that apply)
❒ sitting ❒ going to/rising from sitting
❒ walking ❒ up/down stairs
❒ standing ❒ squatting
❒ lying down ❒ sleeping
❒ looking up overhead ❒ sustained bending
❒ reaching overhead ❒ reaching in front of body
❒ reaching behind back ❒ reaching across body
❒ repetitive activity _____
❒ household activity _____
❒ recreation/sports including _____
❒ coughing/sneezing ❒ taking a deep breath
❒ talking ❒ chewing ❒ yawning ❒ swallowing
❒ stress

11) What relieves your symptoms? (Check all that apply)
❒ nothing ❒ medication ❒ wearing splint/orthosis
❒ rest ❒ cold ❒ heat
❒ sitting ❒ standing ❒ walking ❒ lying down
❒ stretching ❒ exercise ❒ massage

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You may fill out the following questions on our Patient Portal visit http://www.therapeuticassociates.com to get started. Otherwise please complete and bring in for your first appointment.

MEDICATIONS

❒ Consent for Electronic Download of Medication History.
Or
Please list any prescription medications you are currently taking (*pain pills, injections and/or skin patches, etc.*):

_____

_____

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

❒ aspirin ❒ Advil/Motrin/Ibuprofen
❒ Tylenol ❒ corticosteroids
❒ antihistamines ❒ vitamins/mineral supplements
❒ other_____

OCCUPATION INFORMATION

Occupation_____

❒ employed full time ❒ student
❒ employed part time ❒ retired
❒ self employed ❒ unemployed
❒ homemaker ❒ other_____

Physical activities at work? ____

_____

Are you currently receiving or seeking disability for this condition? ❒ Yes ❒ No

If not performing your normal activities at work do you plan to RETURN to your previous activity level? ❒ Yes ❒ No

LIVING ENVIRONMENT

❒ live alone ❒ live with others
❒ home/apartment ❒ retirement complex (SNF/ICF)
❒ assisted living complex

❒ stairs (railing) ❒ no stairs ❒ uneven ground
❒ stairs (no railing) ❒ ramp ❒ elevator
❒ other _____

GENERAL HEALTH

How would you rate your general health?

❒ Excellent ❒ Average ❒ Poor
❒ Good ❒ Fair

Previous Functional Level

❒ **Independent in all activities** (work, community, home, recreation)
❒ Independent in all self-care activities (bathing, toileting, dressing, etc.)
❒ Difficulty performing self-care activities
❒ Needed assistance with self-care activities
❒ Difficulty performing household chores
❒ Difficulty with activities in community outside of home

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 _____

_____

What is your general stress level?

❒ Low ❒ Medium ❒ High

Caffeinate Intake?

❒ None ❒ Occasional ❒ Moderate ❒ Heavy

Alcohol Intake?

❒ None ❒ Occasional ❒ Moderate ❒ Heavy

Smoking Status?

❒ Never ❒ Former smoker ❒ Current every day
❒ Current some day smoker ❒ Unknown
If smoker how much? _____ ❒ Tobacco ❒ Marijuana

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

MEDICAL HISTORY

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

❒ No diseases or conditions

❒ Cancer ❒ Arthritis
❒ Depression ❒ Osteoporosis
❒ Diabetes ❒ Dental Problems
❒ Circulation/Vascular Problems ❒ Headaches/Migraines
❒ Stroke ❒ Hepatitis
❒ Heart Problems ❒ HIV or AIDS
❒ Pacemaker ❒ Kidney Problems
❒ High Blood Pressure ❒ Lung Problems
❒ Muscle, Joint, or Bone Problems ❒ Stomach Problems

SURGICAL/TESTS HISTORY

❒ No surgeries

Type/Date	*Type/Date*
❒ Shoulder Surgery _____	❒ Hip Surgery _____
❒ Knee Surgery _____	❒ Achilles Tendon Repair _____
❒ ACL Reconstruction _____	❒ Heart Surgery _____
❒ Back Surgery _____	❒ Hip Surgery _____
❒ Joint Replacement _____	❒ Elbow Surgery _____
❒ Ankle/Foot Surgery _____	❒ Neck Surgery_____

Other:_____
Other:_____

Have you had any of the following tests?

❒ none ❒ Bone Scan ❒ Vestibular
❒ x-rays ❒ Arthrogram ❒ Stress X-ray Test
❒ CT Scan ❒ MRI

FAMILY HISTORY

❒ No diseases or conditions

Medical Condition	*relation/onset age if known*
❒ Diabetes	
❒ Alzheimer's	
❒ Heart disease	
❒ Cancer	
❒ Stroke/CVA	
❒ Arthritis	
❒ Rheumatoid arthritis	
❒ Asthma	
❒ Musculoskeletal disease	
❒ Skin disorder	
❒ Osteoporosis	

❒ Mental disorder
❒ Other: _____