PhysioFocus LLC
Orthopedic and Sports Therapy

Patient Registration and Medical History

PATIENT INFORMATION		
Last Name:	First Name:	Middle Initial:
Date of Birth:	Gender:	
Doctor:	Medical Diagnosis:	Surgical Procedure:
Home Phone:	Cell Phone:	Email:
Address:		
City:	State:	ZIP Code:

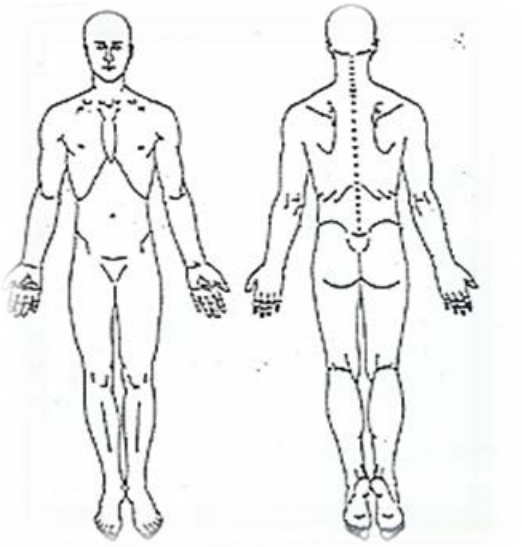
PRIMARY INSURANCE INFORMATION		
Insurance:	ID #:	Group #:
Policy Holders First Name:	Last Name:	
Date of Birth:	Relationship to Patient:	

SECONDARY INSURANCE INFORMATION		
Insurance:	ID #:	Group #:
Policy Holders First Name:	Last Name:	
Date of Birth:	Relationship to Patient:	

MEDICAL HISTORY

1. When did current symptoms start?	2. What was the cause of your pain or symptoms?
3. Are your symptoms related to an injury? ☐ Yes ☐ No	4. Have you had surgery for this problem? ☐ Yes ☐ No

5. Mark areas where you are having pain with a **X.**
Mark areas where you are having numbness / tingling with an **O**



5960 Fairview Road, Suite 250, Charlotte, NC 28210 Phone: 980.224.7958 Fax: 980.224.7973

6. Pain location_____

At worst 0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst Imaginable)
Current 0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst Imaginable)
At best 0 1 2 3 4 5 6 7 8 9 10
(No Pain) (Worst Imaginable)

7. Check the words that best describe your pain / symptoms.

- ☐ Constant
- ☐ Burning
- ☐ Stabbing
- ☐ Shooting
- ☐ Other:
- ☐ Intermittent
- ☐ Dull / Achy
- ☐ Numbness / Tingling
- ☐ Worse in AM PM
- ☐ Throbbing
- ☐ Sharp
- ☐ Worse in PM

8. What makes your pain worse?

- ☐ At rest
- ☐ Standing
- ☐ Stairs Up
- ☐ Stairs Down
- ☐ Bending
- ☐ Lying down
- ☐ Sit to stand
- ☐ Lifting
- ☐ Twisting
- ☐ Voiding
- ☐ Sitting
- ☐ Walking
- ☐ Reaching
- ☐ Coughing/ Sneezing

9. What makes your pain better?

- ☐ Rest
- ☐ Standing
- ☐ Exercise
- ☐ Ice
- ☐ Compression
- ☐ AM
- ☐ PM
- ☐ Other, explain:
- ☐ Lying down
- ☐ Moving
- ☐ Stretching
- ☐ Medication
- ☐ Elevation
- ☐ Bending
- ☐ Turning
- ☐ Sitting
- ☐ Walking
- ☐ Heat
- ☐ Massage
- ☐ Rising
- ☐ When Still
- ☐ On the move

10. What medications are you currently taking?
Dosage?_____

- ☐ Prescription
- ☐ Over the counter
- ☐ Herbals
- ☐ Vitamin/minerals/dietary supplements
- ☐ Not currently taking medication
- ☐ Other_____

11. Check any of the following that apply to your medical history.

- ☐ Heart Prob
- ☐ Stroke / TIA
- ☐ Diabetes
- ☐ Arthritis
- ☐ Metal Implant
- ☐ Emotional / Psy
- ☐ Pacemaker
- ☐ Seizures
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Anemia
- ☐ Bowel / Bladder Prob
- ☐ High BP
- ☐ Lung Prob
- ☐ Infect Dis
- ☐ Hernia
- ☐ Thyroid

Surgeries_____
Allergies_____
Other_____

12. Check any of the following you have had for current problem.

- ☐ Physical Ther
- ☐ Occup Ther
- ☐ Massage Ther
- ☐ EMG or Nerve Conduction
- ☐ X-ray
- ☐ Chiropractor
- ☐ Acupuncture
- ☐ MRI
- ☐ Blood Wk
- ☐ CT Scan

13. Are you working now?
☐ Yes ☐ No

Occupation:_____
Employer:_____

14. Rate your overall general health.
☐ Excellent ☐ Good ☐ Fair ☐ Poor

15. Living situation – I live:
☐ Alone ☐ With spouse ☐ With parents
☐ With Son ☐ With daughter ☐ Other:_____

16. Home environment:
☐ 1 Story ☐ 2 Story ☐ 3 Story
☐ Home ☐ Condo ☐ Apartment
☐ Mobile ☐ Townhome
☐ Stairs ☐ Ramp

17. Please provide your goals and expectations for therapy:

Signature: Date

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