

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:	

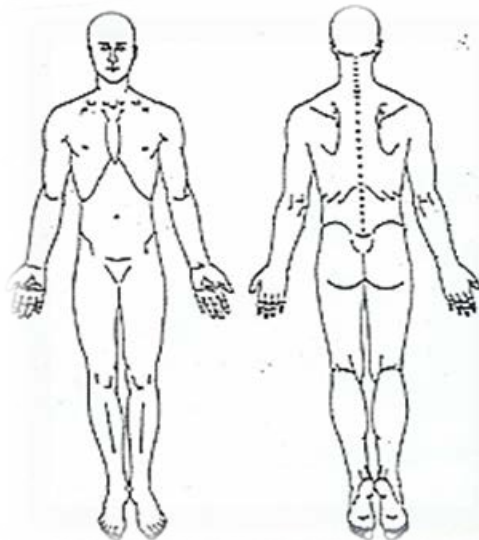
SECONDARY INSURANCE INFORMATION

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Have you had surgery for this problem? <input type="checkbox"/> Yes <input type="checkbox"/> No

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



<p>6. Pain location _____</p> <p>At worst 0 1 2 3 4 5 6 7 8 9 10 (No Pain) (Worst Imaginable)</p> <p>Current 0 1 2 3 4 5 6 7 8 9 10 (No Pain) (Worst Imaginable)</p> <p>At best 0 1 2 3 4 5 6 7 8 9 10 (No Pain) (Worst Imaginable)</p>																															
<p>7. Check the words that best describe your pain / symptoms.</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Constant</td> <td><input type="checkbox"/> Intermittent</td> <td><input type="checkbox"/> Throbbing</td> </tr> <tr> <td><input type="checkbox"/> Burning</td> <td><input type="checkbox"/> Dull / Achy</td> <td><input type="checkbox"/> Sharp</td> </tr> <tr> <td><input type="checkbox"/> Stabbing</td> <td><input type="checkbox"/> Numbness / Tingling</td> <td><input type="checkbox"/> Worse in PM</td> </tr> <tr> <td><input type="checkbox"/> Shooting</td> <td><input type="checkbox"/> Worse in AM PM</td> <td></td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other:</td> </tr> </table>	<input type="checkbox"/> Constant	<input type="checkbox"/> Intermittent	<input type="checkbox"/> Throbbing	<input type="checkbox"/> Burning	<input type="checkbox"/> Dull / Achy	<input type="checkbox"/> Sharp	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Numbness / Tingling	<input type="checkbox"/> Worse in PM	<input type="checkbox"/> Shooting	<input type="checkbox"/> Worse in AM PM		<input type="checkbox"/> Other:			<p>8. What makes your pain worse?</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> At rest</td> <td><input type="checkbox"/> Lying down</td> <td><input type="checkbox"/> Sitting</td> </tr> <tr> <td><input type="checkbox"/> Standing</td> <td><input type="checkbox"/> Sit to stand</td> <td><input type="checkbox"/> Walking</td> </tr> <tr> <td><input type="checkbox"/> Stairs Up</td> <td><input type="checkbox"/> Lifting</td> <td><input type="checkbox"/> Reaching</td> </tr> <tr> <td><input type="checkbox"/> Stairs Down</td> <td><input type="checkbox"/> Twisting</td> <td><input type="checkbox"/> Coughing/ Sneezing</td> </tr> <tr> <td><input type="checkbox"/> Bending</td> <td><input type="checkbox"/> Voiding</td> <td></td> </tr> </table>	<input type="checkbox"/> At rest	<input type="checkbox"/> Lying down	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Sit to stand	<input type="checkbox"/> Walking	<input type="checkbox"/> Stairs Up	<input type="checkbox"/> Lifting	<input type="checkbox"/> Reaching	<input type="checkbox"/> Stairs Down	<input type="checkbox"/> Twisting	<input type="checkbox"/> Coughing/ Sneezing	<input type="checkbox"/> Bending	<input type="checkbox"/> Voiding	
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<p>9. What makes your pain better?</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Rest</td> <td><input type="checkbox"/> Lying down</td> <td><input type="checkbox"/> Sitting</td> </tr> <tr> <td><input type="checkbox"/> Standing</td> <td><input type="checkbox"/> Moving</td> <td><input type="checkbox"/> Walking</td> </tr> <tr> <td><input type="checkbox"/> Exercise</td> <td><input type="checkbox"/> Stretching</td> <td><input type="checkbox"/> Heat</td> </tr> <tr> <td><input type="checkbox"/> Ice</td> <td><input type="checkbox"/> Medication</td> <td><input type="checkbox"/> Massage</td> </tr> <tr> <td><input type="checkbox"/> Compression</td> <td><input type="checkbox"/> Elevation</td> <td><input type="checkbox"/> Rising</td> </tr> <tr> <td><input type="checkbox"/> AM</td> <td><input type="checkbox"/> Bending</td> <td><input type="checkbox"/> When Still</td> </tr> <tr> <td><input type="checkbox"/> PM</td> <td><input type="checkbox"/> Turning</td> <td><input type="checkbox"/> On the move</td> </tr> <tr> <td colspan="3"><input type="checkbox"/> Other, explain:</td> </tr> </table>	<input type="checkbox"/> Rest	<input type="checkbox"/> Lying down	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Moving	<input type="checkbox"/> Walking	<input type="checkbox"/> Exercise	<input type="checkbox"/> Stretching	<input type="checkbox"/> Heat	<input type="checkbox"/> Ice	<input type="checkbox"/> Medication	<input type="checkbox"/> Massage	<input type="checkbox"/> Compression	<input type="checkbox"/> Elevation	<input type="checkbox"/> Rising	<input type="checkbox"/> AM	<input type="checkbox"/> Bending	<input type="checkbox"/> When Still	<input type="checkbox"/> PM	<input type="checkbox"/> Turning	<input type="checkbox"/> On the move	<input type="checkbox"/> Other, explain:			<p>10. What medications are you currently taking? Dosage? _____</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Prescription</td> </tr> <tr> <td><input type="checkbox"/> Over the counter</td> </tr> <tr> <td><input type="checkbox"/> Herbals</td> </tr> <tr> <td><input type="checkbox"/> Vitamin/minerals/dietary supplements</td> </tr> <tr> <td><input type="checkbox"/> Not currently taking medication</td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> </tr> </table>	<input type="checkbox"/> Prescription	<input type="checkbox"/> Over the counter	<input type="checkbox"/> Herbals	<input type="checkbox"/> Vitamin/minerals/dietary supplements	<input type="checkbox"/> Not currently taking medication	<input type="checkbox"/> Other _____
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<p>11. Check any of the following that apply to your medical history.</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Heart Prob</td> <td><input type="checkbox"/> Pacemaker</td> <td><input type="checkbox"/> High BP</td> </tr> <tr> <td><input type="checkbox"/> Stroke / TIA</td> <td><input type="checkbox"/> Seizures</td> <td><input type="checkbox"/> Lung Prob</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Cancer</td> <td><input type="checkbox"/> Infect Dis</td> </tr> <tr> <td><input type="checkbox"/> Arthritis</td> <td><input type="checkbox"/> Osteoporosis</td> <td><input type="checkbox"/> Hernia</td> </tr> <tr> <td><input type="checkbox"/> Metal Implant</td> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> Thyroid</td> </tr> <tr> <td><input type="checkbox"/> Emotional / Psy</td> <td><input type="checkbox"/> Bowel / Bladder Prob</td> <td></td> </tr> </table> <p>Surgeries _____</p> <p>Allergies _____</p> <p>Other _____</p>	<input type="checkbox"/> Heart Prob	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> High BP	<input type="checkbox"/> Stroke / TIA	<input type="checkbox"/> Seizures	<input type="checkbox"/> Lung Prob	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Infect Dis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Hernia	<input type="checkbox"/> Metal Implant	<input type="checkbox"/> Anemia	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Emotional / Psy	<input type="checkbox"/> Bowel / Bladder Prob		<p>12. Check any of the following you have had for current problem.</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Physical Ther</td> <td><input type="checkbox"/> X-ray</td> <td><input type="checkbox"/> MRI</td> </tr> <tr> <td><input type="checkbox"/> Occup Ther</td> <td><input type="checkbox"/> Chiropractor</td> <td><input type="checkbox"/> Blood Wk</td> </tr> <tr> <td><input type="checkbox"/> Massage Ther</td> <td><input type="checkbox"/> Acupuncture</td> <td><input type="checkbox"/> CT Scan</td> </tr> <tr> <td><input type="checkbox"/> EMG or Nerve Conduction</td> <td></td> <td></td> </tr> </table>	<input type="checkbox"/> Physical Ther	<input type="checkbox"/> X-ray	<input type="checkbox"/> MRI	<input type="checkbox"/> Occup Ther	<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Blood Wk	<input type="checkbox"/> Massage Ther	<input type="checkbox"/> Acupuncture	<input type="checkbox"/> CT Scan	<input type="checkbox"/> EMG or Nerve Conduction		
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<p>13. Are you working now?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Occupation: _____</p> <p>Employer: _____</p>	<p>14. Rate your overall general health.</p> <p><input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p>																														
<p>15. Living situation – I live:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Alone</td> <td><input type="checkbox"/> With spouse</td> <td><input type="checkbox"/> With parents</td> </tr> <tr> <td><input type="checkbox"/> With Son</td> <td><input type="checkbox"/> With daughter</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>	<input type="checkbox"/> Alone	<input type="checkbox"/> With spouse	<input type="checkbox"/> With parents	<input type="checkbox"/> With Son	<input type="checkbox"/> With daughter	<input type="checkbox"/> Other: _____	<p>16. Home environment:</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> 1 Story</td> <td><input type="checkbox"/> 2 Story</td> <td><input type="checkbox"/> 3 Story</td> </tr> <tr> <td><input type="checkbox"/> Home</td> <td><input type="checkbox"/> Condo</td> <td><input type="checkbox"/> Apartment</td> </tr> <tr> <td><input type="checkbox"/> Mobile</td> <td><input type="checkbox"/> Townhome</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Stairs</td> <td><input type="checkbox"/> Ramp</td> <td></td> </tr> </table>	<input type="checkbox"/> 1 Story	<input type="checkbox"/> 2 Story	<input type="checkbox"/> 3 Story	<input type="checkbox"/> Home	<input type="checkbox"/> Condo	<input type="checkbox"/> Apartment	<input type="checkbox"/> Mobile	<input type="checkbox"/> Townhome		<input type="checkbox"/> Stairs	<input type="checkbox"/> Ramp													
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<p>17. Please provide your goals and expectations for therapy:</p> 																															
<p>Signature: _____</p>	<p>Date _____</p>																														