New Patient Registration

Please give your cards to the receptionist for copying

Name ______________________________ Date ______________
First MI Last

Address ______________________________
Street City State Zip Code

Social Security Number ______________

Name of person who should receive statement (other than patient) ______________

Statement address (if different from patient's address) ______________

Sex ☐ Female ☐ Male Birth date ______________

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Phone w/area code ______________ Work Phone ______________ Cell Phone ______________

Employer ______________ Occupation ______________

Employer's Address ______________ Your Primary Care Physician ______________

Referring Physician ______________ Date of your next visit ______________

Who should we contact in an emergency? ______________ Phone number ______________

Insurance Information

Primary Insurance ______________

Insured's Name ______________ Insured S.S. # ______________ Insured Birth date: ______________

ID Number ______________ Group Number ______________

Secondary Insurance ______________

Insured's Name ______________ Insured S.S. # ______________ Insured Birth date: ______________

ID Number ______________ Group Number ______________

Please complete if you had a motor vehicle or work accident

Date of accident ______________ How did it happen? ☐ Auto ☐ Work ☐ Other (location) ______________

Attorney's name/address/phone number ______________

Insurance Company (worker's compensation or your auto PIP) ______________

Address ______________ Phone number ______________

Claim Number ______________ Adjuster ______________ Name of insured ______________

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

☐ I was a former patient ☐ a former patient recommended you Name ______________

☐ Doctor recommendation ☐ my family/friend recommended you Name ______________

☐ Insurance Co. recommendation ☐ Newspaper/flyer/website advertisement (please circle)

I learned about you another way. Please explain: ______________

I acknowledge that the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risks of my treatment. I understand that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services.

SIGNATURE ______________ DATE ______________

EMAIL ADDRESS ______________ check to receive FOCUS PT info/updates online ☐

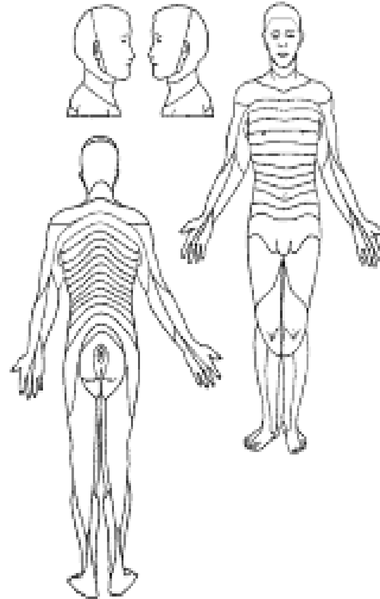
Patient Questionnaire and Health History

Name:_ Date:

determine ies. This information will help your therapist and referring physician give

1 What are your symptoms? ____________________
____

Use the body diagram below to localize areas of pain or abnormal sensation in your body



2 Which of the following best describes how your injury

- ☐ lifting
- ☐ degenerative process
- ☐ an MVA (car accident)
- ☐ during recreation/sports
- ☐ a fall
- ☐ running
- ☐ cumulative trauma
- ☐ unknown
- ☐ throwing
- other: ____________

3 When did you first notice this episode of symptoms
____

4 Nature of your symptoms (check all that apply)

- ☐ sharp ☐ aching ☐ tingling ☐ dull
- ☐ constant ☐ occasional ☐ other ☐ numb

5 Please indicate your pain level on a scale of 0 to 10
________ (zero = no pain, 10 = pain of max severity)

6 How many times in the past have you had symptoms

- ☐ none previously ☐ 1-5 episdoes ☐ more than 5 e

7 Have you ever had an operation on the body region associated with your current symptoms? (check one)

- ☐ no ☐ yes, date: ____________

8 Does the pain wake you at night? ☐ no ☐ yes, # of times:____________

9 As the day progresses, do your symptoms: (check one)

- ☐ increase ☐ decrease ☐ stay the same ☐ change depending on activity

10 Since the onset of your current symptoms have you had: (check all that apply)

- ☐ any difficulty with bowel/bladder fever/chills
- ☐ unexplained weight change
- ☐ any numbness in the genital/anal area
- ☐ night pain/sweats
- ☐ numbness
- ☐ malaise (vague feeling of bodily discomfort)
- ☐ any dizziness or fainting attacks
- ☐ problems with vision/hearing
- ☐ weakness
- ☐ none of the above

11 What aggravates your symptoms? (check all that apply)

- ☐ sitting, time ________
- ☐ reaching overhead
- ☐ coughing/sneezing
- ☐ rising from sitting
- ☐ reaching out/forward
- ☐ taking a deep breath
- ☐ standing
- ☐ reaching behind back
- ☐ sleeping
- ☐ squatting
- ☐ reaching across body
- ☐ looking up/overhead
- ☐ lying down
- ☐ sustained bending
- ☐ swallowing
- ☐ walking, time: ________
- ☐ recreation/sports including: ____________
- ☐ stress
- ☐ up/down stairs
- ☐ other ____________
- ☐ repetitive activities
- ☐ household activities

12 What relieves your symptoms? (check all that apply)

- ☐ sitting
- ☐ changing positions
- ☐ standing
- ☐ lying down
- ☐ walking
- ☐ stretching
- ☐ exercise
- ☐ recreation/sports including: ______________
- ☐ rest
- ☐ cold
- ☐ heat
- ☐ massage
- ☐ traction
- ☐ whirlpool/spa
- ☐ medications
- ☐ nothing
- other: ______________

13 What previous treatments have you had for this problem? (check all that apply)

- ☐ none
- ☐ medication
- ☐ physical therapy
- ☐ joint manipulation by a Chiropractor or Osteopath
- ☐ massage therapy
- ☐ exercise
- ☐ bracing/taping
- ☐ traction
- ☐ joint or spinal injection
- ☐ injection into the skin/ muscles
- ☐ surgery (on the body region of your current problem)
- ☐ biofeedback
- ☐ TENs unit
- ☐ acupuncture
- ☐ bed rest
- ☐ overnight hospitalization
- ☐ hypnosis
- other: ______________

14 Have you had any of the following tests?:

- ☐ none
- ☐ x-rays
- ☐ CT Scan
- ☐ MRI
- ☐ Arthrogram
- ☐ Stress X-ray
- ☐ Bone Scan
- ☐ NCS
- ☐ Other: ______________

Test results: ______________

Please list any prescription medications you are currently taking: ______________

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

- ☐ aspirin
- ☐ Tylenol
- ☐ antihistamines
- ☐ vitamins/mineral supplements
- ☐ Corticosteroids
- ☐ Advil/Motrin/Ibuprofen

Other: ______________

Are you currently working? ☐ yes ☐ no ☐ full-time ☐ part-time ☐ restricted duty

Occupation (specific): ______________

What positions are you in while working? (check all that apply)

- ☐ standing
- ☐ sitting
- ☐ walking
- ☐ bending
- ☐ lifting # lbs: ________ frequency: ________
- other: ______________

Do you exercise on a regular basis? ☐ yes ☐ no

If yes, what type of exercise do you do? ______________ frequency ______

Please list any activities you can't do now as a result of your injury/symptoms: ______________

What goals would you like to achieve with physical therapy? ______________

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
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Multiple sclerosis
- ☐ Arthritis
- ☐ Head Injury
- ☐ Stomach problems
- ☐ Parkinson's disease
- ☐ Circulation/vascular problems
- ☐ Infectious diseases
- ☐ (I.e. hepatitis, tuberculosis, etc.)
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Lung problems
- ☐ Blood disorders
- ☐ Epilepsy/seizures
- ☐ Allergies
- Other: ______________