



ADULT PATIENT REGISTRATION

PATIENT INFORMATION

PATIENT NAME (Last, First, Middle Initial)				
ADDRESS		SOCIAL SECURITY NUMBER		DATE OF BIRTH
CITY	STATE	ZIP	EMAIL ADDRESS	
HOME PHONE NUMBER	WORK PHONE NUMBER	CELL PHONE NUMBER	(Circle One)	Female Male

*****If you have received HELP in the HOME** (bathing, aide help, therapy, nurse visit) in the past three months, please **stop** here, and speak to our receptionist before completing the rest of the patient registration.

For Office Use: (Receptionist - For Medicare patients, call (866) 211-5708 and initial if the patient is already receiving care.) _____

How did you hear about us? Check One: Doctor _____ Advertisement/Radio _____ Internet _____
 Friend/Relative (who?) _____ Employee (who?) _____ Other _____

WHO IS FINANCIALLY RESPONSIBLE FOR TREATMENT?

Myself My Spouse My Parent(s) (Other) or Responsible Party _____

Who is your Primary Care Physician? _____ Which clinic referred you? _____

Who is your Specialty Physician? _____ Other Physician: _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY:	SECONDARY INSURANCE COMPANY:
POLICY NUMBER:	POLICY NUMBER:

POLICY HOLDER'S INFORMATION

NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
ADDRESS (if different from above)		DATE OF BIRTH
CITY	STATE	ZIP
		HOME PHONE (if different from above)
IS THE POLICY HOLDER CURRENTLY EMPLOYED BY THE EMPLOYER PROVIDING INSURANCE? YES NO N/A ARE YOU OR THE PATIENT ON MEDICAL LEAVE? YES NO N/A EMPLOYER NAME: _____ EMPLOYER PHONE NUMBER: _____		

EMERGENCY CONTACT (NOT living with you)

NAME (Last, First, Middle Initial)				RELATIONSHIP TO PATIENT
ADDRESS	CITY	STATE	ZIP	PHONE #
Workers' Comp On-the-job Injury? <input type="checkbox"/> esY <input type="checkbox"/> No			Date of injury: _____	
Employer Name, Contact Person & Phone Number: _____				

Medical History

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

PATIENT'S NAME: _____ **OCCUPATION:** _____

LEISURE ACTIVITIES: _____

Are you currently seeing any of the following?

- | | | |
|------------------------------------|-----------------------------|---------------------------------|
| YES / NO Medical Doctor | YES / NO Physical Therapist | YES / NO Speech Therapist |
| YES / NO Psychiatrist/Psychologist | YES / NO Dentist | YES / NO Occupational Therapist |
| YES / NO Osteopath | YES / NO Chiropractor | |

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

Why are you seeking therapy services?

Have you had any diagnostic tests for this problem (X-Ray, MRI, CT scan, EMG study)?

When: _____ Where: _____ What were the results? _____

Have **you** EVER been diagnosed as having any of the following conditions?

- | | | | | | |
|-----|----|---|-----|----|---------------------------------------|
| YES | NO | Cancer. If YES, describe what kind: _____ | YES | NO | Osteoporosis |
| YES | NO | Heart problems _____ | YES | NO | Depression |
| YES | NO | Pace Maker | YES | NO | Hepatitis |
| YES | NO | Defibrillator | YES | NO | Tuberculosis |
| YES | NO | Circulation problems | YES | NO | Stroke |
| YES | NO | High blood pressure | YES | NO | Pulmonary Embolism |
| YES | NO | Asthma | YES | NO | Kidney disease |
| YES | NO | Emphysema/Bronchitis | YES | NO | Epilepsy |
| YES | NO | Chemical dependency (i.e., alcoholism) | YES | NO | Post Traumatic Stress Disorder (PTSD) |
| YES | NO | Thyroid problems | YES | NO | Dizziness |
| YES | NO | Diabetes | YES | NO | Ringing in the ears |
| YES | NO | Multiple sclerosis | YES | NO | Bowel/Bladder Dysfunction |
| YES | NO | Rheumatoid arthritis | YES | NO | Clinched Jaw/Grinding Teeth |
| YES | NO | Other arthritic conditions | YES | NO | Other _____ |
| YES | NO | Anemia | | | |

Please list any **surgeries or other conditions** for which you have been hospitalized for, including the approximate date and reasoning for the surgery or hospitalization:

DATE	SURGERY/HOSPITALIZATION	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please describe any **injuries** you've been treated for (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	INJURY	DATE	INJURY
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Has anyone in your **family** EVER been diagnosed as having any of the following conditions?

- YES NO Diabetes
- YES NO Tuberculosis
- YES NO Heart disease
- YES NO High blood pressure
- YES NO Stroke
- YES NO Kidney disease
- YES NO Cancer
- YES NO Arthritis
- YES NO Anemia
- YES NO Headaches
- YES NO Epilepsy
- YES NO Mental illness
- YES NO Chemical dependency (i.e. alcoholism)

For office use

Have you taken any of the following OVER-THE-COUNTER medications in the last week?

- YES NO Aspirin
- YES NO Tylenol
- YES NO Advil/Motrin/Ibuprofen
- YES NO Laxatives
- YES NO Decongestants
- YES NO Antihistamines
- YES NO Antacid
- YES NO Vitamins/Mineral supplements
- YES NO Other _____

For office use

Please list any **PRESCRIPTION medications** you are currently taking (INCLUDING pills, injectables, and/or skin patches):

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke per day? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or one glass of wine, how much do you drink at an average sitting? _____

How many days per week do you use marijuana? _____

How many days per week do you use drugs such as cocaine, crack, acid, etc.? _____

Females – Are you pregnant? YES / NO In the past week, have you felt depressed or down? YES / NO

In the past week, have you had problems falling asleep or staying asleep? YES / NO

How do you best learn? _____

Have you **recently** noted any of the following?

- YES NO Weight loss/gain
- YES NO Nausea/vomiting
- YES NO Fatigue
- YES NO Weakness
- YES NO Fever/chills/sweats
- YES NO Numbness or tingling

For office use

Form reviewed with patient? YES _____ NO _____

Patient's Signature: _____

Date: _____

Therapist's Signature: _____

Date: _____