PATIENT REGISTRATION

Name: (Last) _____ (First) _____ (MI) _____ (Jr., Sr., etc.) Sex: M or F

Street Address: _____ Apt./Space: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Marital Status: _____

CONTACT INFORMATION (Check the box next to the best contact number)

□Home phone: _____ □Work Phone: _____ □Cell Phone: _____

Email address: _____

EMERGENCY CONTACT: _____ Relation: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

PARENT / RESPONSIBLE PARTY FOR PAYMENT: _____ Date of Birth: _____

Address: (If different from above) _____

City: _____ State: _____ Zip Code: _____ Phone: _____

INSURANCE INFORMATION

Primary Ins: _____ **Insured Name:** _____ **DOB:** _____

Secondary Ins: _____ **Insured Name:** _____ **DOB:** _____

On the job injury? □YES □NO

Worker's Comp Insurance Co. Date of Injury: _____ Claim #: _____ Adjuster's Name _____

Auto Accident? □YES □NO Date of Injury: _____ Claim #: _____ Adjuster's Name _____

Attorney's Name: _____ Attorney's Phone: _____

PREVIOUS THERAPY INFORMATION

Have you received any other Therapy Services this calendar year? □YES □NO

Have you received, or are you currently receiving Home Health Therapy? □YES □NO

If yes, please provide dates: _____ and the name of Home Health Agency: _____

Have you received, or are you currently receiving Chiropractic Treatment? □YES □NO

I hereby authorize payment of medical benefits to _____, for services furnished to me. I also hereby consent to have treatment and care as prescribed by my physician and / or recommended by the therapist. I also authorize the therapist to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. I HEREBY ACCEPT FINANCIAL RESPONSIBILITY FOR ALL CHARGES INCURRED WHETHER OR NOT I HAVE INSURANCE COVERAGE. VERIFICATION OF BENEFITS WE RECEIVE FROM YOUR INSURANCE COMPANY IS NOT A GUARANTEE OF PAYMENT.

_____ _____

Patient or Responsible Party Signature Date

MEDICAL HISTORY FORM

NAME: _____ DATE: _____
REFERRING PHYSICIAN: _____ DATE OF BIRTH: _____
FAMILY PHYSICIAN: _____

MEDICAL HISTORY

Is your current condition related to an injury? **Yes____** **No____**
If YES, was the injury related to: **Auto____** **Work____** **Other____** **Date of Injury** _____

Are there any lawsuits pending regarding your condition? **Yes____** **No____**

Have you received physical/speech therapy in the last year? **Yes____** **No____**
If YES, refer to your insurance policy for limitations.

Please check any of the following conditions you have or may have had in the past:

_____ Heart Disease	_____ Tuberculosis	_____ Asthma
_____ High Blood Pressure	_____ Currently Pregnant	_____ Stroke
_____ Heart Murmur	_____ Pacemaker	_____ C.O.P.D.
_____ Mood Disorders	_____ Chest Pain/Discomfort	_____ Hepatitis
_____ Shortness of Breath	_____ Ankle Swelling	_____ Anemia
_____ Kidney Disease	_____ Epilepsy/Seizures	_____ Diabetes
_____ Dizzy Spells	_____ Allergies	_____ Hernia
_____ Headaches	_____ Cancer: Type_____	
_____ Loss of Bladder/Bowel Control	_____ Other: _____	

ORTHOPEDIC LIMITATIONS

Please check any of the following conditions that you have or have had in the past:

_____ Osteoporosis	_____ Scoliosis
_____ Broken Bones	_____ Sprains/Strains
_____ Arthritis	_____ Balance/Walking Problems
_____ Fibromyalgia	_____ Limited Range of Motion
_____ Slipped/Ruptured Disc	_____ Subluxed/Dislocated Joints
_____ Weakness	_____ Painful Grinding/Cracking in a Joint
_____ Compression Fractures	

Have you had a recent: X-Ray____ MRI____ CT Scan____
If so, when? _____ _____ _____

Please list hospitalizations or surgeries you have had:

_____

_____

Please list any medications you are currently taking:

_____

Are you allergic to any medications: Yes____ No____ If yes, please list: _____

Signature: _____ Date: _____
PT Signature: _____ Date: _____