

*Clinic Patient ID Sticker*

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had **surgery** for your condition?  Yes No If yes, date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had injections for your condition? Yes No If yes, date(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any **diagnostic tests** you have had for this condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you previously had, or are you currently receiving, any of the following services for your condition: physical therapy, chiropractic care, acupuncture, massage or personal training? Yes No

**What** are your current symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Where** is your pain or problem located? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**When** did the injury or symptoms occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How** did the injury or symptoms occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please rate your pain using a 0- 10 scale** (0= no pain, 10= worst pain you can imagine)

**Worst** pain since onset: \_\_\_\_\_\_ **Lowest** pain since onset: \_\_\_\_\_\_ **Today’s** pain \_\_\_\_\_\_

Is your pain? Constant Comes and goes Is there pain present at night? Yes No

What position helps you sleep? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain **better**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Worse**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What do you hope to accomplish with therapy**? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any recent **falls**? (within the past 3 months) Yes No *If yes*, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you worry about falling? Yes No

***\*STAFF USE ONLY,*** *TUG Test*: Seconds: \_\_\_\_\_\_\_\_ Level of assistance: \_\_\_\_\_\_\_\_\_ Asst. device:\_\_\_\_\_\_\_\_\_\_

Do you have dizziness? Yes No

What type of non-work activities are you involved in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When are you scheduled to see your doctor again? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your overall health status (check one)? Poor Fair Good Excellent

Would you like to speak to someone about **abuse or neglect** that you have recently experienced? Yes No

I consent to be treated in an open gymnasium atmosphere: Yes No

*If you marked “Yes”- if at any time during the course of your therapy you would prefer to be treated in a more private area, please tell your therapist and they will make appropriate accommodations.*

Are you currently working? Yes No If no, how many total days of work have you missed? \_\_\_\_\_\_\_\_\_\_\_\_

Are your work duties: Restricted Full How many hours per week do you work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your employer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of work do you do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What work duties have been most affected by your problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*See Page 2 for signatures and dates**

**Medical History Form**

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Are you allergic to latex? Yes No

Do you have any other allergies? Yes\* No \*If yes, please list below:

|  |  |
| --- | --- |
| **Allergies or Drug Allergies** | **Reaction/ Symptoms when allergy occurs** |
|  |  |
|  |  |
|  |  |

Check this box if you have brought a list of your current medications, so that you will not have to complete the below medication list. Please give your list to our office staff for your chart.

**For Clinician Use Only**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Current Medication List** *(Include over-the-counter & herbal)* | **Dosage** | **Frequency** | **New** | **D/C** | **Date/ Initials** |
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**Please check any conditions that apply to you:**

|  |  |
| --- | --- |
|  | Joint Replacement or Metal Implant If so, what area?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  | Heart Disease |  | Diabetes |  | High blood pressure |  | Asthma |
|  | Fibromyalgia |  | Insulin Pump |  | Visual Impairment |  | Epilepsy or Seizures |
|  | HIV/ AIDS |  | Arthritis |  | Hearing Impaired  |  | Cancer |
|  | Depression |  | Tuberculosis |  | Osteoporosis |  | Scoliosis |
|  | Generalized Anxiety Disorder |  | Thyroid Problem |  | Pregnant |  | Stroke |
|  | Defibrillator/Pacemaker |  | Alcohol Use |  | Tobacco Use |  | Weight change (<10 lbs) |
|  | Multiple Sclerosis (MS) |  | Ehlers-Danlos |  | Other: \_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| **Surgical History** *(use back of this page, if needed)* | **Date**  | **Additional Medical History** | **Date**  | **If new, Clinician Initial/ Date** |
|  |  |  |  |  |
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How do you learn best? *Check all that apply* Written Verbal Visual Demonstration

\*To the best of my knowledge and belief, the information that I have given is complete and true\*

**\*Patient Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Time:** \_\_\_\_\_\_\_\_\_\_\_

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**Personal Representative and Information Form**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize Physical Therapy at Patterson, a part of Bon Secours St. Mary’s Hospital to release information about my medical care to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Relationship)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Relationship)

I understand that I must notify the above listed entity in writing in order to terminate this designation. I also understand that the above named entity is not responsible for information that is re-disclosed by the above named individual(s).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Date

|  |  |  |
| --- | --- | --- |
| Date of Accident/ Incident or Onset of Recent Symptoms: | Type of Incident: Auto Work | No AccidentOther: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

Would you like information in reference to financial assistance? Yes No

Do you have transportation issues which may prevent you from attending therapy? Yes No

**Advanced Directive Information:**

Written Living Will for Medical Choices: Yes No If yes, location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Written Medical Power of Attorney: Yes No If yes, location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**Outpatient Registration Form**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Today’s Date**: | **Last Name**: | **First Name**: | **Middle Init**. | **Gender** |
| **Date of Birth:** | **Maiden Name**: | **Marital Status**: | **Race/ Ethnicity**: | **Religion**: |
| **Social Security #:** | **Primary Care Physician:** | **What language do you wish to discuss your healthcare in?** |
| **Home Address:** | **Apt #** | **City** | **State** | **Zip Code** |
| **Home Phone#** | **Cell Phone #** | **Email Address:**  |
| *Check this box if you do not wish to be contacted via e-mail* |
| **Employer’s Name:** Please check: Full-Time Part-Time Not Employed Retired FT Student | **Employer’s Phone #** |
| **Primary Insurance Holder/ Sponsor’s Name and Relationship** | **Insurance Company Name** |
| **Date of Birth:** | **Holder/ Sponsor’s SSN:** |
|  |  |
| **Secondary Insurance Holder/ Sponsor’s Name and Relationship** | **Insurance Company:** |
| **Date of Birth** | **Holder’s/ Sponsor’s SSN:** |
|  |  |
| **Secondary Insurance Holder/ Sponsor’s Name and Relationship** | **Insurance Company:** |
| **Date of Birth** | **Holder’s/ Sponsor’s SSN:** |
|  |
| **Emergency Contact Name** | **Relationship** | **Home Phone #** | **Cell Phone #** |
| **Emergency Contact Employer Name** | **Work Phone #** |