STRENGTH PHYSICAL THERAPY
Patient Registration

Today's Date:_____

Please fill-out entire form completely and legibly.

PATIENT INFORMATION

_____ _____ Date of Birth:_____
Last Name *First name*

Gender: □ *Male* □ *Female* *Civil Status:* □ *Single* □ *Married*

_____ _____ _____ _____
Street Address *City* *State* *Zip*

(____)_____ (____)_____ _____
Home Phone *Cell Phone* *Email Address*

_____ _____ (____)_____
Occupation *Employer Name* *Employer Phone No.*

_____ _____ (____)_____
Emergency Contact Person *Relationship* *Phone No.*

_____ _____
IF Patient is a Minor: Parent/ Guardian Name *Parent/Guardian Signature*

Work Status: □ *Currently Working* □ *Retired* □ *Disabled (____Total/ _____Temporary)*

Student: : □ *Full time* □ *Part Time*

PATIENT CONDITION INFORMATION

AUTO INJURY	***WORK INJURY***	***NO INJURY***
Date of Accident___/___/____	*Date of Injury:_____/____/_____* *Your Company HR contact person:_____* *Insurance Adjustor Name:* _____ *Adjustor Phone No_____*	*What do you think may have caused it?* _____ _____

I have already had.....

Surgery	***Physical Therapy Before:***	***Home Physical Therapy***
Date of Surgery____/____/____ *Type of Surgery_____* _____	*When?_____* *Where?_____*	*Are you still receiving it?* *_____Yes _____No*

PAYMENT INFORMATION (please check only one)

□ Insurance. *Patient must fill up the "* ***Assignment of Benefit Form".***
□ Worker's Compensation. *Patient must provide complete information under patient condition above.*
□ Cash, Check or Credit Card.

REFERRAL INFORMATION

□ Referred by Physician/Medical/Health Practitioner. Name _____
□ If not referred by physician, how did you hear about us? □ Friend/Family □ Brochure/Ads
□ Social Media/Internet □ Others_____

□ *I have attest that the information given are true to the best of my knowledge.* ***Signature***_____

STRENGTH PHYSICAL THERAPY

PAST MEDICAL HISTORY FORM

Date:___/___/_____

Patient Name:_____ Age: _____ Date of Next Physician's visit (if any): ___/___/_____

Date of Injury or onset of Symptoms:___/___/_____ Have you had these symptoms before? _____ Yes _____ No

Check which apply to your symptoms:

- ☐ Work related
- ☐ Motor Vehicle accident
- ☐ Cause unknown
- ☐ Recurrence of previous injury
- ☐ Athletic/recreational injury
- ☐ Other:_____

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Liver / Gallbladder Problems	☐	☐
Hypoglycemia	☐	☐	Stroke / CVA	☐	☐
Hypothyroidism	☐	☐	Bowel/Bladder Dysfunction	☐	☐
Hyperthyroidism	☐	☐	Urine Leakage	☐	☐
Chest Pain / Angina	☐	☐	Allergies to Aspirin	☐	☐
High Blood Pressure	☐	☐	Poor tolerance to Heat	☐	☐
Low Blood Pressure	☐	☐	Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitations	☐	☐	Seizures	☐	☐
Pacemaker / Cardiac Stents	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Vertigo / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Cancer	☐	☐	Surgeries	☐	☐
Osteoporosis	☐	☐	Skin Abnormalities	☐	☐
Osteoarthritis	☐	☐	Sexual Dysfunction	☐	☐
Rheumatoid Arthritis	☐	☐	Nausea / Vomiting	☐	☐
Asthma/ Breathing Difficulties	☐	☐	Ringing in your ears	☐	☐
COPD	☐	☐	Do you smoke?	☐	☐
Congenital Dysfunction	☐	☐	Are you pregnant?	☐	☐

If you answered "YES" to any of the above, please briefly explain and give approximate date:

_____

_____

Is there any other information regarding your past medical history that we should know about?

_____

_____

Are you presently taking Medications? _____ Yes _____ No

If yes, please list your medications below and indicate for which condition you take them for:

_____

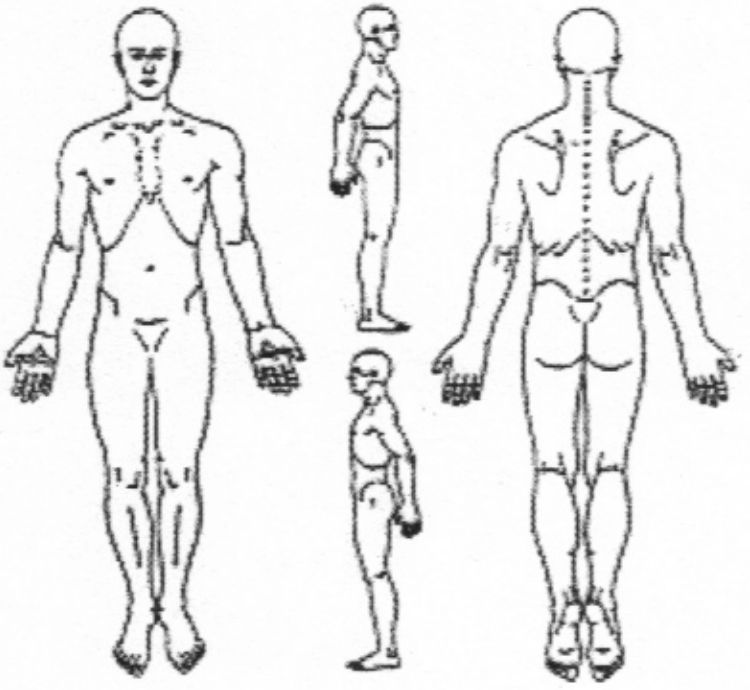
_____

STRENGTH PHYSICAL THERAPY

Past Medical History Form
Pain Diagram

If you are having pain, please rate the intensity of your pain on a scale if 0 to 10, with 0 being NO PAIN, and 10 being the WORST pain possible: _____.

Please indicate below where your symptoms are located:



KEY:

Numbness	- - - - - - - - -
Pins and needles	o o o o o o o
Burning pain	x x x x x x x x
Stabbing pain	> > > > > > >
Aching pain	/ / / / / / / / /

_____ ____/____/_____
Patient's signature Date

_____ ____/____/_____
Signature of Guardian, if patient is a minor Date

_____ ____/____/_____
Physical Therapist's signature Date