Precision in Movement & Performance Physical Therapy Patient Registration Form

Patient Name	DOB	Gender ☐M ☐F	Social Security
Address		City/State/Zip	
Home Phone	Work Phone		Cell Phone
Email	I give consent to be reminded of appointments and be contacted by: ☐Phone Call ☐ Text ☐Email ☐No Reminders		Referral Source
Emergency Contact (Name)	Relation to Patient		Cell Phone
Address	City/State/Zip		
Briefly describe the history of your present accident, injury, or illness			
Injury Date	Body Region Involved		
Pain Level from 0-10, with 0 being no pain. Please explain			
Please list recent diagnostic studies (X-ray, MRI, CT Scan			
Do you have any metal in your body? (Pins, Plates, Pacemaker) Where? ☐ Yes ☐ No	Please List any allergies you have:		
Please list current medication with dosage			
Have you been injured by a fall this year? ☐ Yes ☐ No	Have you had unusual weight gain/loss lately? ☐ Yes ☐ No	Have you taken steroids/anti-coagulants for over a year? ☐ Yes ☐ No	
Is condition surgery related? ☐ Yes ☐ No	Date of Surgery	Surgical Procedure	
Please list any past surgeries and date if applicable			
Is condition accident related? ☐ Yes ☐ No	Was an automobile involved? ☐ Yes ☐ No	Date of Accident	
Describe Accident/Injury/Illness			
Were you injured on the job? ☐ Yes ☐ No	Date of Injury	Are you currently working? ☐ Full-time ☐ Part-time ☐ No	
Name of employer at time of accident	City, State, Zip Code		
Is litigation (lawsuit) involved? ☐ Yes ☐ No	Name of Attorney	Phone #	
Are you currently receiving healthcare service through a Home Health Agency (HHA)? ☐ Yes ☐ No	HHA Name	HHA Phone #	
Insurance Provider	Patient Responsibility	ID Card Number	

Medical History: Check box if you have you ever had the following

					Problems with
☐Anemia	☐Depression	☐Hepatitis	☐Seizures	☐Cardiac Conditions	☐Circulation
☐Anxiety	☐Diabetes	☐Incontinence	☐Strokes	☐Currently Pregnant	☐Kidney
☐Arthritis	☐Dizzy Spells	☐Implants	☐Osteoporosis	☐Gallbladder Issues	☐Speech
☐Asthma	☐Emphysema	☐Parkinson's	☐Thyroid Disease	☐High Blood Pressure	☐Vision
☐Cancer	☐Fractures	☐Pacemaker	☐Chemical Depen.	☐Multiple Sclerosis	☐Hearing

By initialing and signing below I agree to the provided policies and testify that the above information is true

Consent to Treatment_____ Cancellation Policy_____ Credit Card Policy_____

Patient Signature: Date: Parent/Guardian Signature: