

## REGISTRATION FORM

Name			ate	
Last	First	MI		
Mailing AddressStreet		City	State	Zip Code
Physical Address		Percentus.	3500,000000	100,177,0020,107,002
Street		City	State	Zip Code
Home Phone w/area code	Work Phone	C	ell Phone	
Contact Preference: Home Work	Cell	-mail Address		
Social Security Number	Birth date		Sex: Female	Male
Marital Status: Single Married Do	omestic Partner; Registered in:	Spouse/Partner's Name	Div	orced  Widowed
Employer	Employer's Address			
Primary Care Physician		eferring Physician		
Emergency Contact		Relationship		
Home Phone w/area code	Work Phone	c	ell Phone	
INSURANCE INFORMATION – PLEASE GIVE Y	OUR CARDS TO THE FRONT DESK	FOR SCANNING		
Primary Insurance				
Subscriber's Name		Birth date		
ID Number		Group Number		
Secondary Insurance				
Subscriber's Name		Birth date		
ID Number		Group Number		<u> </u>
IF YOU HAD AN ACCIDENT PLEASE COMPLET	10.000 - 0.000 - 0.000 - 0.000 - 0.000 - 0.000 - 0.000 - 0.000 - 0.000 - 0.000 - 0.000 - 0.000 - 0.000 - 0.000			
Date of accident How	did it happen?  Auto  Wor	k Other State in which	injury occurred	
Claim Number Insuran	ce Company (worker's comp or yo	our auto PIP)		
Address	Claims Adjuster	Phone	number	

 $\Rightarrow$ 

I verify that the above information is accurate (Signature)

(Date)\_\_\_\_



## **PATIENT QUESTIONNAIRE / HEALTH HISTORY**

NAME:	DA1	ΓE:	
To insure you receiv	e a complete and thorough	evaluation.	please provide

us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

1. What are your symptoms?	7. Nature of pain/symptoms (check all that apply)  (1) sharp (4) aching (7) constant (2) dull (5) periodic (8) other (3) throbbing (6) occasional
Localize areas of <b>pain</b> or <b>abnormal</b> sensation on the body chart below (Shade in where appropriate)	8. As the day progresses, do your symptoms: (Check one)  (1) increase (2) decrease (3) stay the same
	9. Does the pain wake you at night? ☐ (1) No ☐ (2) Yes if "yes", is it present ☐ (1) while lying still ☐ (2) only when changing positions ☐ (3) both
	10. Do you have pain/stiffness upon getting out of bed in the morning? (1) Yes (2) No
	11. In what position do you sleep? (Check all that apply) ☐ (1) right side ☐ (4) back ☐ (6) back, sides, stomach ☐ (2) left side ☐ (5) chair/recliner ☐ (7) other ☐ ☐ (3) stomach
	12. Since the onset of your current symptoms have you had:  (1) any difficulty with control of bowel or bladder function (2) fever/Chills (3) any numbness in the genital or anal area (4) numbness (5) any dizziness or fainting attacks (6) weakness (7) unexplained weight change (8) night pain/sweats (9) malaise (vague feeling of bodily discomfort) (10) problems with vision/hearing
When did your symptoms begin?     (Please indicate a specific date if possible)	☐ (11) none of the above  13. What aggravates your symptoms? (Check all that apply) ☐ (1) sitting ☐ (9) repetitive activities
3. Was the <b>onset</b> of this episode gradual or sudden?(Check one)  (1) gradual  (2) sudden	☐ (2) going to/rising from sitting including including (10) household activities
4. Which of the following <b>best describes</b> how your injury occurred? (if your condition is post-surgical please indicate as per original injury)    (1) lifting	☐ (4) walking including ☐ (5) up/down stairs ☐ (11) standing ☐ (12) squatting ☐ (13) sleeping ☐ (14) coughing/sneezing ☐ (15) taking a deep breath ☐ (16) reaching across body ☐ (15) taking a deep breath ☐ (17) talking, chewing, yawning, all (circle one) ☐ (17) swallowing ☐ (18) stress ☐ (19) sustained bending ☐ (20) other ☐ (20)
5. Since onset, are your symptoms getting: (Check one)  (1) better (2) worse (3) not changing	14. What relieves your symptoms? (Check all that apply)  ☐ (1) sitting ☐ (6) rest ☐ (11) massage ☐ (2) heat ☐ (7) standing ☐ (12) medication ☐ (3) cold ☐ (8) walking ☐ (13) nothing
6. Have you had similar symptoms in the past? (1)☐ Yes (2)☐ No More than one episode? (1)☐ Yes (2)☐ No	☐ (4) stretching ☐ (9) exercise ☐ (14) other ☐ (5) wearing a ☐ (10) lying down splint/orthosis

15. Have you had any previous tre	eatment for this condition?	L	IVING SITUATI	ION
(Check all that apply)		☐ (1) live alone		☐ (6) assisted living
☐ (1) none	☐ (11) hypnosis	(2) live with family	members/others	complex
(2) medication (oral)	(12) biofeedback	(3) live with careging		☐ (7) other
(3) joint manipulation	☐ (13) TENS unit	(4) home/apartmer		
(4) exercise	(14) acupuncture	(5) retirement com		
☐ (5) massage therapy	(15) bed rest	Setting	p.o. (0.11,10.)	
(6) traction	(16) overnight		1 (2) no stairs	☐ (6) uneven ground
` ,		(1) stairs (railing)	1 (3) 110 Stall S	(6) uneven ground
(7) bracing/taping	hospitalization	(2) stairs (no railing)	J (4) ramp	☐ (7) other
(8) injection into the spine	(17) casting	(no railing)	(5) elevator	
(9) injection into the skin/muscles	☐ (18) other			
☐ (10) physical therapy		G	<b>ENERAL HEAL</b>	.тн
		How would you rate you	ır general health	n?
16. Have you had any of the followin	g tests?		J Average	☐ Poor
☐ (1) none	(7) Bone Scan		J Fair	<b>1</b> 1 001
☐ (2) x-rays	☐ (8) NCS	L Good	J Fall	
☐ (3) CT Scan	(9) Fluoroscope			
		Do you exercise outside	of normal daily	activities?
☐ (4) MRI	(10) Vestibular	☐ 5+ days/wk	<b>J</b> 1-2 days/wk	□ zero
(5) Arthrogram	☐ (11) other	☐ 3-4 days/wk	occasionally	
(6) Stress X-ray Test (Telos)				of
Test Results:				
				_
MEDICATIO	ON	Do you drink coffeington	d hayaraaa2	
Please list any prescription medication		Do you drink caffeinated		, ,
(pain pills, injections and/or skin pate		□ No □	Yes How mar	ny/much per day
(pain pilis, injections and/or skin pate	nes, etc.).			
		Do you smoke?		
-			Yes Packs of	cigarettes per day
Prescribing MD:	Phone:			3 · /
		What is your stress leve	12	
Are you currently taking any of the	following over the counter		J Medium	☐ High
medications?	-	L LOW	Mediuiii	□ High
(1) aspirin	☐ (6) Advil/Motrin/			
		Are you seeing any heal	lth care providei	rs other than the physical
(2) Tylenol	Ibuprofen			ease list)
☐ (3) corticosteroids	☐ (7) other	arcrapios for ano carren	(11	
□ (4) antihictaminec				
(4) antihistamines		-		<u> </u>
(4) antifistal lines (5) vitamins/mineral supplements				
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