PATIENT REGISTRATION

NAME ____ DATE OF BIRTH ________________
FIRST MI LAST

ADDRESS ____
STREET CITY STATE ZIP

PHONE INFO: MOBILE ______________________________ ☐ **BEST WAY TO CONFIRM APPOINTMENTS**

HOME ______________________________ ☐ ☐ CALL ☐ TEXT ☐ EMAIL

WORK ______________________________ ☐

EMAIL ADDRESS ______________________________________ ☐ MALE ☐ FEMALE

IF YOU ARE A MINOR, GUARDIAN NAME ______________________________ RELATION ______________

EMERGENCY CONTACT: NAME ________________________ PHONE ________________

WHO CAN WE SHARE OR DISCUSS YOUR HEALTH INFORMATION WITH? ______________________________

HAVE YOU HAD PHYSICAL THERAPY FOR ANY PREVIOUS CONDITION? ☐ YES ☐ NO IF YES, WHEN__________

HEALTH INSURANCE INFORMATION

PRIMARY __________________________ ID# ________________________ GROUP # ________________

SUBSCRIBER ____________________________ DATE OF BIRTH ______________ RELATION ____________

SECONDARY __________________________ ID# ________________________ GROUP # ________________

SUBSCRIBER ____________________________ DATE OF BIRTH ______________ RELATION ____________

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN ____________________________________ PHONE # ____________________

ADDRESS ____
STREET CITY STATE ZIP

REFERRING PHYSICIAN ____________________________________ PHONE # ______________________

ADDRESS ____
STREET CITY STATE ZIP

PLEASE BE SURE TO COMPLETE THE OTHER SIDE OF THIS FORM ➔

OFFICE USE ONLY ID#______________ PT________ POST/OP______ DIA____________________ CC________ S/A_____ CHECK________

ACKNOWLEDGEMENTS

Please read the provided documents and sign below to acknowledge your agreement.

SPECHT PHYSICAL THERAPY FINANCIAL POLICY

PRINT NAME : ______________________________ SIGNATURE: ______________________________ DATE: __________

APPOINTMENT ATTENDANCE POLICY

PATIENT SIGNATURE: ______________________________ DATE __________

CONSENT TO TREAT

PATIENT SIGNATURE: ______________________________ DATE __________

WITNESS SIGNATURE: ______________________________ DATE __________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ______________________________, have reviewed the Notice of Privacy Practices from Specht Physical Therapy.

SIGNATURE: ______________________________ DATE: __________

AUTO INJURIES, WORK INJURIES and PERSONAL INJURIES ONLY – please complete the following section:

INJURY DATE __________ INJURY TYPE: ☐ WORK ☐ AUTO ☐ SLIP / FALL ☐ OTHER

IF **WORK** RELATED, DID YOU REPORT THIS TO YOUR EMPLOYER? ☐ YES ☐ NO CLAIM # __________

EMPLOYER NAME ______________________________

IF AN **AUTO** ACCIDENT, IN WHAT STATE DID THE ACCIDENT OCCUR? __________

HAVE YOU FILED A CLAIM FOR THIS INJURY ☐ YES ☐ NO CLAIM # __________

INSURANCE COMPANY ______________________________ PHONE __________

ADDRESS ______________________________ CONTACT PERSON __________

DO YOU HAVE AN ATTORNEY ☐ YES ☐ NO NAME __________

ADDRESS ______________________________ PHONE __________

NAME: ______________________ DATE ________

HISTORY & MEDICATIONS

Systemic Disorders	Yes	No
Systemic Arthritis (RA, Lupus, Other)	☐	☐
Unexplained rashes, sores or swelling	☐	☐
Fibromyalgia/ Chronic Fatigue	☐	☐

Blood Disorders	Yes	No
Bleeding disorders	☐	☐
Clotting disorders	☐	☐
History DVT (Blood Clots)	☐	☐
Currently taking blood thinners	☐	☐
Peripheral vascular disease	☐	☐

Cancer	Yes	No
History of cancer, any type	☐	☐

Cardiovascular	Yes	No
Heart Attack	☐	☐
Chest pain or Angina	☐	☐
Fainting	☐	☐
Heart rate restrictions w/ ex. (per MD)	☐	☐

Endocrine/Metabolic	Yes	No
Diabetes	☐	☐
Osteoporosis	☐	☐

Immunologic	Yes	No
HIV	☐	☐
HEP B, HEP C	☐	☐

Neurologic	Yes	No
Stroke/TIA	☐	☐
MS/Parkinson's	☐	☐
Seizure disorder	☐	☐
Poor balance with frequent falls	☐	☐
Recent tremors or clumsy walking	☐	☐
Numbness/tingling both hands or feet	☐	☐

Pulmonary	Yes	No
Asthma	☐	☐
Shortness of breath with exercise	☐	☐
Require the use of an inhaler	☐	☐

Other	Yes	No
Currently pregnant (or think you might be)	☐	☐
Do you have a pacemaker	☐	☐
Do you have metal implants	☐	☐
Severe cold intolerance/Raynaud's	☐	☐
Poor tolerance to NSAID's	☐	☐
Severe food or drug allergies	☐	☐
Vision or hearing difficulties	☐	☐

Constitutional symptoms (Current)	Yes	No
Fever/ chills/ nights sweats	☐	☐
Severe fatigue/malaise	☐	☐
Nausea/vomiting	☐	☐
Dizziness/fainting	☐	☐
Unexplained weight loss, >10% BW	☐	☐

How would you describe your current fitness level: ___Excellent ___Good ___Fair ___Poor

How often do you exercise weekly: ___None ___1-2x ___3-4x ___5+

What is your general stress level: ___Low ___Moderate ___High ___Overwhelmed, feeling hopeless

Who have you seen for your current condition:
___Primary MD ___Orthopedic MD ___Other MD ___PT ___Chiropractor

What Tests or Procedures have been done for your current condition:
___X-Rays ___MRI/CT Scan ___Bone Scan ___EMG ___Blood Work

What Treatment has been performed for your current condition:
___None ___Medication ___Injection(s) ___PT ___Surgery date: __________

Current Medications – use other side if additional

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________
7. ______________________
8. ______________________