Patient Registration Form

Patient Information:

Name: ____________________Age: ________DOB: ______________Male/Female/Prefer not to say (Circle)
Address: ____________________________________City, State, Zip: _______________________________
Primary Phone:_______________________________ Second Phone: ________________________________
Email: __________________________________ Preferred method of contact: Text/Call/Email/Other (Circle)
Referral Source: Doctor/Friend/Internet/Advertisement (Circle) The Name: ____________________________
Your Physician: ____________________________ Your Last visit(Date): _____________________________

Primary Insurance:
Name of Insurance: ____
Policy #: ______________________________________ Group #: ____________________________________
Policy Holder Name: _______________________________ DOB: _____________________________________
SSN #:_____________________________________ Their Phone #: __________________________________

Secondary Insurance:
Name of Insurance: ____
Policy #: ______________________________________ Group #: ____________________________________
Policy Holder Name: _______________________________ DOB: _____________________________________
SSN #:_____________________________________ Their Phone #: __________________________________

Responsible Party:
Name: _________________________________ DOB: _____________ SSN#___________________________
Relationship to Patient: Parent/Guardian/Self/Other (Circle). Name: ___________________________________
Address: ____________________________________City, State, Zip: _________________________________
Primary Phone:_______________________________ Second Phone: __________________________________
Email: _____________________________________ Preferred method of contact: Text/Call/Email/Other (Circle)
Employer: ______________________________ Work Phone #: ______________________________________
Employer Address: _______________________________ City, State, Zip:______________________________

Below is my Signature and by signing this, I attest that all the information provided is true and complete. If this injury/illness is work related I will let both my employer and my doctor know before starting therapy. I authorize the release of any necessary medical information and/or payment of medical benefits to the physician for services rendered. I understand and agree that: 1) I was provided a copy of the Notice Privacy Practices and have read them and understood them; 2) I am fully responsible for all charges to me, including the balance remaining after payment of insurance benefits (as per your insurance contract); 3)A $25.00 fee will charged on each returned check; 4) payment is expected at the time of services are rendered unless prior arrangement are made; 5) the information in this document can not be altered by me or my representative.
***ALL COPAYS/PAMENTS ARE DUE AT THE TIME OF SERVICE*.**

Responsible Party Signature: ______________________________ Date: ____________________

Witness Signature: _______________________________ Date: __________________________

Patient History Form

Name: ______________________________ Local Phone # __________________________

Local Address ________________________________Email: ________________________

Do you have any barriers to learning? Yes/ No If yes, please explain: ___________________________

Gender: M / F

Date of birth: ____________

Smoker: Yes / No

Pregnant: Yes / No

Occupation______________

How would you rate your general health? Excellent Good Fair Poor

Do you exercise at least 3 times/week? Y / N

Past surgeries: (list & date) ____________________________________

____

Current (prescription, over the counter): ____________________________

____

<u>Past Medical History: Have you ever been told you have any of the following?</u>

Cancer	Yes	No	Ulcers	Yes	No
Heart problems	Yes	No	Infectious diseases	Yes	No
High Blood Pressure	Yes	No	Lung problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	Anemia	Yes	No
Diabetes	Yes	No	Allergies	Yes	No
Osteoporosis	Yes	No	Fibromyalgia	Yes	No
Thyroid problems	Yes	No	Kidney disease	Yes	No
Rheumatoid arthritis	Yes	No	Stroke	Yes	No
Osteoarthritis	Yes	No	Seizures/Epilepsy	Yes	No
Depression	Yes	No	Other		

<u>Currently, are you experiencing any of the following? (circle all that apply):</u>

Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss	
Numbness/tingling	Changes in appetite	Difficulty swallowing	Pelvic pain
Depression	Shortness of breath	Changes in bowel or bladder function	
Dizziness	Nausea/vomiting	Night pain	Headaches

How have you been sleeping at night? Fine. Disturbed Why? ____________ With medication.

During the past month, have you been bothered by feeling down, depressed or hopeless? Y / N

During the past month, have you had little interest or pleasure in doing things? Y / N

Current History:

What date (approximately) did your present symptoms start?

____

____

How? (gradually, suddenly, injury)

____

____

How have your symptoms changed?: getting better about the same getting worse

What makes your symptoms better?

____

____

What makes your symptoms worse?

____

____

Have you had an x-ray, MRI, or other testing for this problem? No / Yes (specify)

____

____

What treatments have you received for this problem so far?

____

____

On the scale below, circle the number which best represents the average level of pain you have experienced over the last 48 hours:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

Circle the number below which best represents your overall average level of function:

0 1 2 3 4 5 6 7 8 9 10

Cannot do anything I can do everything

Impact

Therapy Solutions

Pediatric and Adult Therapies

(254)892-0527

Aggravating Factors: Identify up to 3 important activities that you are unable to do or have difficulty with as a result of your problem.

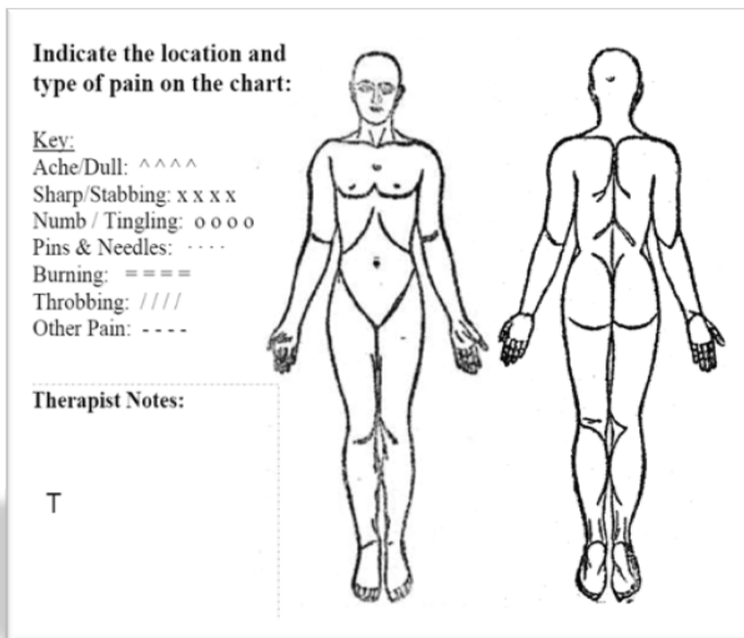
1) ____
2) ____
3) ____

During the past 3 months, have you seen any medical professional (doctor, chiropractor, PT,

osteopath, etc.)? Yes / No If yes, please describe the reason. ______________________________

List any other injuries you have had that required medical attention. __________________________

What are your personal goals for therapy at this time? ___________________________________



Therapy Solutions
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CONSENT: My diagnosis and treatment plan will be discussed during my appointment and I understand that I have the right to question and/or refuse any treatment offered. The information I have provided above is accurate and complete.

______________________________ _________________
(Patient signature) (date)

______________________________ _________________
(Therapist signature) (date)