ANDREW E. SPATAFORE, MSPT **MATTHEW A. MADRID, MSPT**

PATIENT REGISTRATION FORM

Patient Name _____Date of Birth _____

Street Address_____

City _____State _____ Zip _____

Mailing Address _____

Home Phone _____(C) _____ (W) _____

Age_____ SS# _____ Marital Status: Married Single

Height _____ Ft _____ inches Weight _____ pounds

Your Employer Name & Phone _____

Your Occupation _____

Spouse _____ Spouse Date of Birth _____

Spouse's Employer Name & Phone _____

1) Name Of Emergency Contact 2) Phone Number 3) Patient Relationship

1) _____2) _____ 3) _____

Referring Physician _____ Next Doctors Appt _____

Primary care physician _____ Next Doctors Appt _____

If You Are A Minor:

Father's Name _____Phone _____

Father's Employer _____

Mother's Name _____ Phone _____

Mother's Employer _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

Were you injured at work? **Yes No**

How did the pain start? Mark all that apply - ◇Injury ◇Suddenly ◇Gradually ◇Ongoing Problem ◇Unsure

◇Work ◇Auto Accident ◇Home ◇Sports ◇Lifting ◇Twisting ◇Bending ◇Pulling ◇Slip/Fall ◇Other

(Please Explain) _____

When did this episode of pain start? Exact Date _____ Surgery Date _____

_____ Days Ago _____ Weeks Ago _____ Months Ago _____ Years Ago

DID YOU RECENTLY HAVE HOME HEALTH FOR THIS INJURY/ PROBLEM? YES / NO

IF YES, WE NEED YOUR DISCHARGE DATE _____

WE WILL NEED A COPY OF YOUR INSURANCE CARDS, DRIVER'S LICENSE OR PHOTO ID

***IF YOU HAVE HEALTHSMART BENEFIT SOLUTIONS INSURANCE (FORMERLY WELLS FARGO/PEIA)**

AQUATIC THERAPY IS NOT A COVERED BENEFIT AND THE INSURANCE WILL NOT PAY FOR THE POOL.*

Primary Insurance _____

Name of Insured _____ Date of Birth _____

Secondary Insurance _____

Name of the Insured _____ Date of Birth _____

Have you been evaluated or treated by another healthcare provider other than your referring physician for this condition? **Yes No**

In the past year, have you had any of the following? **Yes No** (Circle all that apply)

Physical / **O**ccupational / **S**peech Therapy **A**cupuncture **C**hiropractic **C**are

If **YES**, how many visits and when were you seen?

P _____ O _____ S _____ A _____ CC _____

Pain is **Increased** by _____

Pain is **Decreased** by _____

What are you being seen for today? (Primary Complaint) _____

_____

Have you fallen in the past 12 months? **Yes** **No** How many times? _____

Do you use tobacco? **Yes** **No** How much? _____

Do you use alcohol? (circle one) Yes No

Are you pregnant? **Yes** **No** **NA** Are you planning to be pregnant? **Yes** **No** **NA**

Are you allergic to any medications? **Yes** **No** What?_____

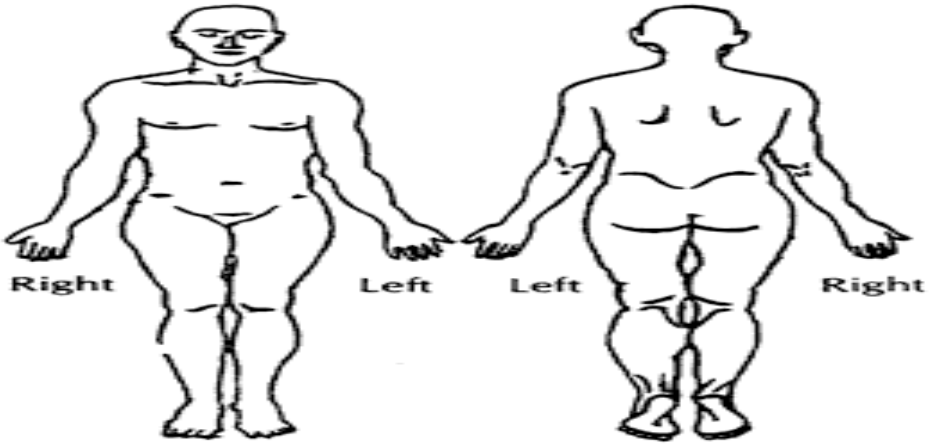
Prior Hospitalizations or Major Surgeries _____

_____

Please circle any prior or recent testing relating to this condition? X-ray MRI CT Scan EMG Blood Work Bone Scan

What facility were these tests done? UHC Morgantown Other _____

Rate Your Pain	**0 = Pain Free**										**10 = <u>Passing Out</u> from Pain**
Right Now	0	1	2	3	4	5	6	7	8	9	10
Worst in past 24 hours	0	1	2	3	4	5	6	7	8	9	10
Best in past 24 hours	0	1	2	3	4	5	6	7	8	9	10



Please use the diagram and indicate where you feel your symptoms.
Use the following key and write on the bodies the type of pain you feel.

Key: Pins & needles = 0000, Numbness = NNNN, Burning = XXXX
Deep Ache = ZZZZ, Stabbing pain = ////

PLEASE TURN OVER AND COMPLETE OTHER SIDE

Please mark the following if you have ever been diagnosed or treated for:

( ) Heart condition _____
( ) Irregular heart beat _____
( ) Circulatory problems _____
( ) High Blood Pressure _____
( ) Shortness of breath _____
( ) Chest pain or pressure _____
( ) Calf pain _____
( ) Swollen ankles or legs _____
( ) Fainting or dizziness _____
( ) Stroke / CVA _____
( ) Blurred vision _____
( ) Recent weight loss / gain _____
( ) Balance problems _____
( ) Frequent falls _____
( ) Tremors _____
( ) Tingling / Numbness / Loss of feeling _____
( ) Difficulty swallowing _____
( ) Bowel / Bladder problems _____
( ) Weakness or Fatigue _____
( ) Epilepsy /Seizures / Convulsions _____
( ) Recent Accident _____
( ) Headaches _____
( ) Whiplash _____
( ) Head Trauma / Concussion _____
( ) Joint dislocations _____
( ) Pacemaker _____

( ) Broken bones _____
( ) Back or Neck Injury _____
( ) Muscle pain with activity_____
( ) Fibromyalgia _____
( ) Unusual reaction to heat or cold _____
( ) Night pain (while sleeping) _____
( ) Hernias _____
( ) Pain with cough or sneeze _____
( ) Stomach pain / ulcers _____
( ) Diabetes _____
( ) Wound that does not heal _____
( ) Osteoporosis _____
( ) Arthritis _____
( ) Swollen or painful joints _____
( ) Jaw problems/ TMJ _____
( ) Kidney Disease _____
( ) Liver Disease _____
( ) Lung Disease _____
( ) Unusual skin coloration _____
( ) Latex Allergy _____
( ) Cancer / Tumors _____
( ) Nervous or emotional problems _____
( ) Difficulty sleeping _____
( ) Infectious Disease (HIV / Hepatitis) _____
( ) Allergies (Medication) _____
( ) Joint Replacement _____

IF YOU <u>DO NOT HAVE A COPY</u> OF YOUR MEDICATIONS, <u>PLEASE LIST THEM</u>:

_____
_____
_____

(Please read the attached Notice of Information Practices and the Consent for treatment information before signing this page.)

I understand and agree that I am ultimately responsible for payment of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to Affiliated Physical Therapy, LLC. By signing below I indicate that I have read and agree with the Notice of Information Practices and the Consent for Treatment Information.

Signature: _____ Date: _____

Parent's signature, if patient is a minor:

_____ Date: _____