Athalon Physical Therapy Registration

Appt______@________

Full Legal Name ____ DOB ____/____/______

Phone # ___________________________

Address ____ Apt# ____________

City _____________________________________ State ____________ Zip __________________

Email _____________________________________

What are you coming in for - Injury/Body part _______________________________________

Is this from a Car Accident/No Fault or Work Related? NF WC (circle one)

Are you using Insurance? Yes No

If your insurance plan requires a Referral, please have your Primary Care Doctor submit it to your insurance.

Primary Insurance _____________________________ ID#_____________________________

Name of Plan Subscriber __________________DOB_____/_____/____ Relation___________

Insurance Company Phone # ____

Secondary Insurance ___________________________ ID#_____________________________

Name of Plan Subscriber __________________DOB_____/_____/____ Relation____________

Referring Doctor____

How did you hear about us _______________Physician _______________Direct Access ______

Please Complete

Home Phone #___________________ Work # ___________________ Cell # _______________

Gender M F Social Security # ____/____/____ Email_______________________________

Emergency Contact _____________________Relation________________Phone# _________________

PRINT NAME: _____________________ **SIGN x** ____________________ **DATE** ___________

Name: ____

CURRENT CONDITION/CHIEF COMPLAINT

1. Describe problem ____
____
2. What activities is this problem interfering with? ____
____
3. When did it begin? ____
4. What happened? ____
5. Are you seeing anyone else for the problem? ____

Have you received physical therapy this year? □ yes □ no If yes, for how long? _______________

Have you had physical therapy for this condition? □ yes □ no If yes, for how long? ______________

Are you: □ right handed? □ left handed?

MEDICAL/SURGICAL HISTORY - Please check if you have ever had:

□ Arthritis	□ Broken bones/fractures	□ Osteoporosis	□ Blood disorders
□ Multiple sclerosis	□ High blood pressure	□ Heart problems	□ Lung problems
□ Circulation/vascular problems	□ Diabetes/high blood sugar	□ Stroke	□ Seizures/epilepsy
□ Head injury	□ Muscular dystrophy	□ Parkinson's disease	□ Cancer
□ Low blood sugar/hypoglycemia	□ Allergies	□ Depression	□ Thyroid problems
□ Developmental/growth problems	□ Kidney problems	□ Repeated infections	□ Skin diseases
□ Ulcer/stomach problems	□Infectious disease (e.g. tuberculosis, hepatitis)		

□ Other: ______________________________

Within the past year, have you had any of the following symptoms? (Check all that apply)

□ Chest pain	□ Heart palpitations	□ Cough	□ Hoarseness
□ Shortness of breath	□ Dizziness or blackouts	□ Coordination problems	□ Weakness in arms/legs
□ Loss of balance	□ Difficulty walking	□ Joint pain or swelling	□ Pain at night
□ Difficulty sleeping	□ Loss of appetite	□ Nausea/vomiting	□ Difficulty swallowing
□ Bowel problems	□ Weight loss/gain	□ Urinary problems	□ Fevers/chills/sweats
□ Headaches	□ Hearing problems	□ Vision problems	□ Other: ___________

Have you ever had surgery? □ Yes □ No If yes, please describe and include dates: __________________

MEDICATIONS: Please list any medications you take and for what reason: _____________________________
____

OTHER CLINICAL TESTS – Within the past year, have you had any of the following tests? (Check all that apply)

□ Angiogram	□ Arthroscopy	□ Biopsy	□ Blood tests
□ Bone scan	□ Bronchoscopy	□ CT Scan	□ Doppler ultrasound
□ Echocardiogram	□ EEG (electroencephalogram)	□ EKG (electrocardiogram)	□ EMG (electromyogram)
□ Mammogram	□ MRI	□ Myelogram	□ NCV (nerve condion velocity)
□ Pap smear	□ Pulmonary function test	□ Spinal tap	□ Stool tests
□ Stress test (e.g., treadmill, bicycle)		□ Urine tests	□ X-rays

SOCIAL/HEALTH HABITS

Do you smoke? □ Yes □ No If yes, how often? ______________________

Do you drink alcohol? □ Yes □ No If yes, how often? ______________________

Do you exercise? □ Yes □ No If yes, please describe the exercises ______________

FAMILY HISTORY - Indicate what relative and age of onset, if known.

Heart disease: ______________________ Hypertension: ______________________

Stroke: __________________________ Diabetes: __________________________

Cancer: __________________________ Psychological: ______________________

Arthritis: _________________________ Osteoporosis: ______________________

Other: ____

For women only:

Do you have a history of/or currently have: Trouble with your period □Yes □No Complicated pregnancies? □Yes □ No

Are you pregnant, or think you might be pregnant? □Yes □No

Other gynecological or obstetrical difficulties? □Yes □No If yes, please describe: ______________________