Great Falls Physical Therapy

Registration

1. ABOUT YOU

_____	_____	_____	_____
Last Name	First Name	Middle Initial	You prefer to be called:
_____	_____	____Male ____Female ____Prefer not to answer	
Birthdate	Age	Gender (at birth)	
_____	_____	_____	
Your height	Your weight	Who referred you to our office?	
_____	_____	_____	_____
Mailing/Street Address	City	State	Zip Code
_____	_____	_____	
Home Phone Number	Cell Phone	E-mail Address	

2. INSURANCE INFORMATION

_____	_____	_____	_____
Insurance Name	Member ID	Group Number	Phone Number for Providers
_____	_____	_____	_____
Mailing Address	City	State	Zip Code
_____	_____	_____	
Subscriber Name	Subscriber DOB	Relation to Patient	

3. IN THE EVENT OF EMERGENCY: Whom should we contact?

_____	_____	_____	_____
Name	Relation to Patient	Home Phone	Cell Phone
_____	_____	_____	
Primary Care Provider	Phone Number	Fax Number	

Medical History

4. REASON FOR VISIT

Reason for today's visit: __Wellness __Chronic pain __ Old injury __ New injury __Emergency

Using a scale from 0 to 10, with 0 being "no pain" and 10 being the "worst pain imaginable," please describe:

- Your current level of pain while completing this survey:
  0 1 2 3 4 5 6 7 8 9 10
- The best your pain has been during the past 24 hours:
  0 1 2 3 4 5 6 7 8 9 10
- The worst your pain has been during the past 24 hours:
  0 1 2 3 4 5 6 7 8 9 10

_____ _____

Date your condition/accident occurred? Where did your injury occur?

_____

Please explain what happened:

- Has this or something similar happened in the past? __Yes __No

_____

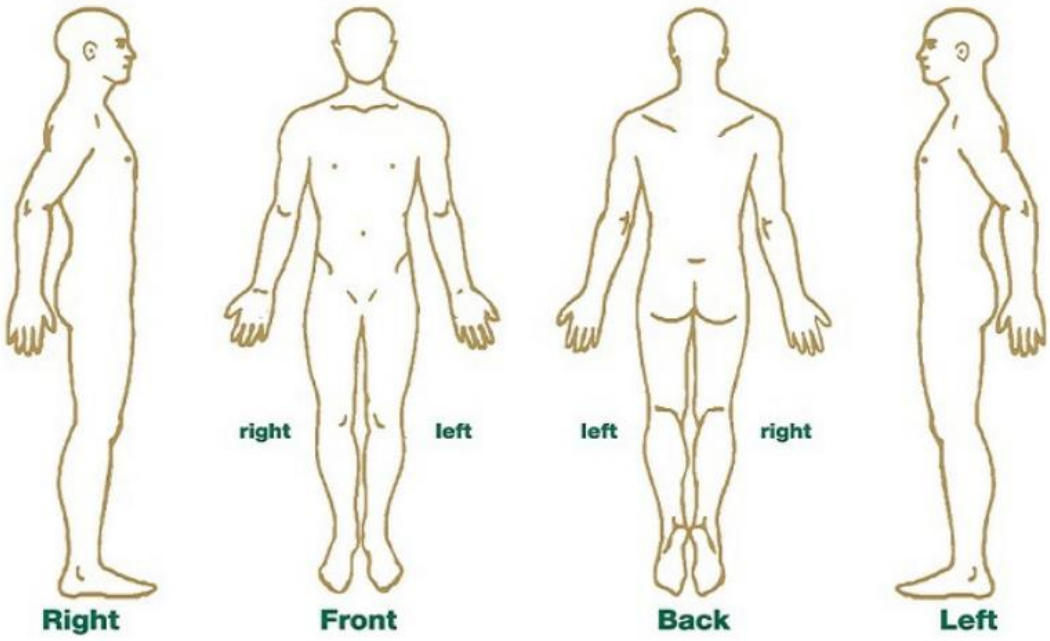
If you have experienced this problem in the past, when?

_____

What treatment did you receive for this PAST problem?

_____ _____ _____

How long did it take you to feel better? What treatment do you think your symptom responded to best?



Please indicate the location of your symptoms in the above diagram.

List treatments or tests performed for this problem: (Chiropractic, injections, x-rays, MRI, blood work, etc.)

- Has a Medical Physician treated the condition? __Yes __No

_____	_____	_____
Medical Physician Name	Phone Number	Fax Number

- Have you ever had physical therapy before? __ Yes __ No

5. MEDICAL INFORMATION

Please list any medications you are taking. (Pills, injections, skin patches, over-the-counter)

- Have you ever taken steroid medications for any medical conditions? __ Yes __ No
- Have you ever taken blood thinning or anticoagulant medications for any conditions? __Yes __ No

Please list any medications to which you may be allergic

- Have you RECENTLY noted any of the following (check all that apply)?

__ Fatigue __Headaches __Changes in bladder function __Changes in bowel function __Falls
__Cough __Difficulty swallowing __ Balance problems __Fainting __Heartburn/Indigestion
__Weight loss/gain __Shortness of breath __ Dizziness/Lightheaded __Nausea/Vomiting __Diarrhea
__Muscle weakness __Fever/Chills/Sweats __Constipation __ Numbness or Tingling
__I don't have any of these problems

- During the past month, have you ever been feeling down, depressed, or hopeless? __ Yes __ No
    - Is this something you would like help with? __Yes __Yes, but not today __No

- Do you have or have you EVER had any of the following diseases, medical conditions, or procedures?

__Cancer __Pacemaker __Chest Pain/Angina __Glaucoma __Thyroid problems __Liver problems
__Heart Surgery __Stroke __Heart Attack _HIV+ / AIDS / ARC __Lung problems __Pneumonia
__ Pelvic inflammatory disease __Bladder/urinary tract infection __Other arthritic conditions
__Circulation problems __Osteoporosis __ Multiple sclerosis __Rheumatoid arthritis __Blood clots
__Bone or joint infection __Depression __Sexually transmitted disease __Kidney Problems/Infection
__Arthritis __Artificial Bones/Joints/Implants __Lower Back Problems __Chemotherapy
__Difficulty Breathing __Tuberculosis __Emphysema __Asthma __Sinus problems __Shingles
__Fainting/Seizures/Epilepsy __Ulcerative colitis __Severe/Frequent Headaches __Rheumatic Fever
__Psychiatric problems __High/Low Blood pressure __Anemia __Diabetes __Congenital Heart Defect
__Frequent neck pain __Eye problem/infection __Mitral Valve Prolapse __Artificial Valves __Hepatitis
__Alcohol / Drug Abuse

_____

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

Are you latex-sensitive? __Yes __ No

- Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply) ? __Not applicable

__Blood clots __Depression __High blood pressure __Thyroid problems __Stroke __Heart problems __Tuberculosis __Diabetes __Cancer

- Do you take Supplements or Vitamins? Yes / No
- Do you exercise? Yes / No _____Hours per week
- Do you smoke? Yes / No _____How much do you smoke?
  _____How long have you smoked?
- Are you wearing: __Shoe lifts __Inner soles __Arch supports
- Are you dieting: Yes / No _____Date Since Starting Diet
- Are you Pregnant? Yes / No _____How many children have you had?

We invite you to discuss any questions regarding our services with us. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for services rendered at the time of visit unless other arrangements have been made with the business manager. If the account is not paid within 90 days of the service date and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.

I authorize the staff to perform necessary services during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand all the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

_____ _____

Signature Date