ADVANCED PHYSICAL THERAPY & REHAB

ACCT #_____

Carefully read through the front and back of this confidential form and complete each section as accurately and completely as possible. Be sure to sign and date the back of this form at the designated location. Please return this form to the front desk and provide a form of identification and any relative insurance card(s) such that a copy can be retained for billing and record keeping purposes.

PATIENT REGISTRATION FORM

FIRST NAME: _____ **MI**: _____ **LAST NAME**: _____

DATE OF BIRTH: _____ **SSN**: _____-_____-_____ **PHONE (MAIN)**: _____

ADDRESS: _____ **PHONE (ALT.)**: _____

CITY: _____ **STATE**: _____ **ZIP CODE**: _____

REFERRING PHYSICIAN: _____ **CLINIC PHONE**: _____

EMPLOYER NAME: _____ **PHONE**: _____

OCCUPATION: _____ **RESTRICTIONS** (Circle): **FULL-DUTY / LIGHT-DUTY / UNABLE**

EMERGENCY CONTACT NAME: _____ **RELATIONSHIP**: _____

ADDRESS: _____ **CITY**: _____ **STATE**: _____ **PHONE**: _____

HEIGHT: _____ **WEIGHT**: _____ lbs. Are you… (Circle)? **MARRIED / SINGLE / DIVORCED / WIDOWED**

GENDER: ☐ Male ☐ Female ☐ N/A Do you **SMOKE**? ☐ Yes ☐ No If **YES**, how much? _____

Are you **PREGNANT**? ☐ Yes ☐ No Do you drink **ALCOHOL**? ☐ Yes ☐ No If **YES**, how much? _____

Do you regularly **EXERCISE**? ☐ Yes ☐ No Type of **EXERCISE ACTIVITIES**: _____

PAST MEDICAL HISTORY

- ☐ Cancer
- ☐ Osteoarthritis / Rheumatoid Arthritis
- ☐ Osteoporosis / Weak Bones
- ☐ Bone / Joint Infection
- ☐ Vision / Hearing Difficulties
- ☐ Heat / Cold Intolerance
- ☐ Thyroid Problems
- ☐ Dizziness / Fainting
- ☐ Vascular Disease
- ☐ Chest Pain / Heart Attack
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Anemia
- ☐ Blood Clots / Emboli
- ☐ Gastric/Peptic Ulcer Disease
- ☐ Bladder/Urinary Tract Infection
- ☐ Kidney Problems
- ☐ Stroke / TIA
- ☐ Multiple Sclerosis
- ☐ Fibromyalgia
- ☐ Epilepsy / Seizures
- ☐ Depression / Anxiety
- ☐ Asthma / COPD
- ☐ Severe / Frequent Headaches
- ☐ Lung Problems
- ☐ Diabetes I or II
- ☐ Liver Problems
- ☐ Lower Back Pain
- ☐ Other(s): _____

Does anyone in your immediate family have a history of Diabetes, High Blood Pressure, Cardiac Problems, Stroke, or Cancer? ☐ Yes ☐ No

If **YES**, please list condition and relationship: _____

ALLERGIES: _____

MEDICATIONS (e.g., Prescription, OTC, Supplements): _____

_____

PAST SURGERIES: _____

IMAGING (Circle): **X-RAY CT Scan MRI Other(s)**: _____

MEDICAL DEVICES (e.g., Implant, Pacemaker, Spinal Stimulation): _____

In the past month, have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

In the past month, have you been bothered by having little interest/pleasure in doing activities you previously enjoyed? ☐ Yes ☐ No

Have you ever had thoughts of suicide or hurting yourself/others? ☐ Yes ☐ No

Are these feelings something with which you would like help? ☐ Yes ☐ No

RECENT MEDICAL HISTORY

- ☐ Fatigue
- ☐ Fever / Chills / Sweats
- ☐ Nausea / Vomiting / Diarrhea
- ☐ Abdominal Pain
- ☐ Pain at Night
- ☐ Unexplained Weight Loss/Gain
- ☐ Recent Falls / Trauma
- ☐ Pain with Sexual Activity
- ☐ Numbness / Tingling
- ☐ Muscle Weakness
- ☐ Balance / Coordination Issues
- ☐ Changes in Bladder/Bowel (e.g., Color, Consistency, Frequency)
- ☐ Dizziness / Lightheadedness
- ☐ Fainting
- ☐ Ringing of Ears
- ☐ Vision Changes
- ☐ Headache / Migraine
- ☐ Cough / Sneezing
- ☐ Shortness of Breath
- ☐ Chest Pain / Tenderness
- ☐ Difficulty Swallowing
- ☐ Heartburn / Reflux / Ulcers
- ☐ Skin Discoloration

CURRENT MEDICAL STATUS

Describe your **CURRENT SYMPTOMS**: _____

DATE the symptoms started: _____ **ONSET** (Circle): **GRADUAL** / **SUDDEN**

Have you received **PREVIOUS TREATMENT** for the condition? ☐ Yes ☐ No

If **YES**, what kind of therapy or medication? _____

Is this **INJURY**… (Circle)? **WORK-RELATED** / **AUTO ACCIDENT** / **POST-SURGICAL** / **NONE OF THESE**

Are your **SYMPTOMS** …? ☐ Achy ☐ Deep ☐ Constant ☐ Superficial ☐ Dull ☐ Sharp ☐ Shooting
☐ Tingling ☐ Burning ☐ Numb ☐ Other: _____

What makes your symptoms **WORSE**? _____

_____

_____

What makes your symptoms **BETTER**? _____

_____

_____

Do the symptoms get **WORSE** or **BETTER** throughout the **DAY** (Circle)? **WORSE** / **BETTER** / **STAY THE SAME**

Do the symptoms get **WORSE** or **BETTER** at **NIGHT** (Circle)? **WORSE** / **BETTER** / **STAY THE SAME**

Overall, are your **SYMPTOMS**… (Circle)? **IMPROVING** / **GETTING WORSE** / **NO CHANGE**

What **ACTIVITIES** are you currently **UNABLE** to do? ☐ Squatting ☐ Sitting ☐ Lying down ☐ Twisting ☐ Bending
☐ Lifting < 10 lbs. ☐ Lifting >10 lbs. ☐ Standing ☐ Walking ☐ Stairs ☐ Cleaning ☐ Exercise
☐ Kneeling ☐ Holding/Carrying Objects ☐ Dressing/Grooming ☐ Rising from a Chair
☐ Repetitive Activities ☐ Other(s): _____

Using a scale of 1-10 (1 = lowest and 10 = highest), please **RATE YOUR PAIN**…

CURRENTLY? _____ / 10
AT WORST? _____ / 10
AT BEST? _____ / 10

I hereby agree and give my consent to medical treatment in treating my physical conditions. I authorize release of any medical information needed to aide in my care and treatment and to process my claim(s) for my insurance company or benefactor company, and request release of payment benefits directly to UNIVERSAL REHAB SERVICES, INC. to settle my account(s). I understand that I am responsible for any charges that are not covered by my insurance carrier or benefactor company. Furthermore, I understand that I am responsible for informing the office of any changes that occur regarding my insurance coverage, including but not limited to changes in effective dates, termination of coverage, starting new/additional coverage, and changes to membership plans. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

I acknowledge that I have seen the "Notice of Privacy Practices" and understand under the Privacy Act of 1974, my personal and private information will be used solely for the purpose of my care and treatment and to process my claim(s) on my behalf. I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

PATIENT / GUARDIAN SIGNATURE: _____ **DATE**: _____