4125 Dick Pond Road
Myrtle Beach, SC 29588

(We are in the Carolina Fitness building)

Phone: (843) 999-0284
Fax: (833) 284-5756
Web: parphysicaltherapy.com

Registration

1. ABOUT YOU

Last Name

First Name

Middle Name or Initial

You prefer to be called:

Gender

◯ Male ◯ Female
◯ Prefer not to answer

Birthdate: mm/dd/yyyy

Age

Social Security Number:

Your height

Your weight

Who referred you to our office?

Mailing/Street Address

City

State

ZipCode

Home Phone Number:

Work Phone Number:

Cell Phone (555) 222-4444

E-mail Address

Employer's Name/Company

Employer's Address, City, State, Zip

What is your Occupation?

Status:

◯ Widowed ◯ Separated ◯ Divorced ◯ Married ◯ Single ◯ Minor

Spouse's Name

Do you have children?

◯ No ◯ Yes

How many Children?

2. INSURANCE INFORMATION

Primary Health Insurance Co. Name

Insurance Co. Address, City, State, Zip

Insurance Co. Phone # (555) 222-3333

Insured's ID#

Group #: (Plan, Local, or Policy #)

Insured's Name

Relation to Patient

Insured's Date of Birth mm/dd/yyyy

Insured's Employer

Secondary Insurance

Insurance Co. Address, City, State, Zip

Insurance Co. Phone # (555) 333-4444

Insured's ID#

Group #(Plan, Local, or Policy #)

Insured's Name

Insured's Relation to Patient

Insured's Date of Birth mm/dd/yyyy

Insured's Employer

3. ACCOUNT INFORMATION

Person responsible for account

What is your relation to patient

Billing Address, City, State, Zip

Social Security # 222-33-4444

Driver's License #

Work Phone #(555) 333-4444

I hereby authorize assignment of my insurance rights and benefits to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Please click to acknowledge you agree with the above statement.

○ I do not Agree ○ I Agree

What is your preferred payment method?

☐ Credit Card ☐ Check ☐ Cash

4. IN EVENT OF AN EMERGENCY

Whom should we contact?

Relation to Patient

Home Phone #(333) 222-4444

Work Phone #(222) 333-4444

Cell Phone #(222) 333-4444

Who is your Medical Doctor?

MD's Phone #(444) 222-5555

Medical History

5. REASON FOR VISIT

Reason for today's visit:

○ Wellness ○ Chronic pain ○ Old injury ○ New injury ○ Emergency

Are you in pain?

○ Yes ○ No

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

Did your injury occur during:

☐ Routine/Household activity ☐ Work ☐ Sports/play ☐ Auto Accident

Date your condition/accident occured?

Where did your injury occur?

Please explain what happened:

Are your symptoms currently:

☐ Staying about the same ☐ Getting Better

☐ Getting Worse

Is your condition interfering with your:

☐ Work ☐ Sleep ☐ Daily routine?

How has your condition interfered?

How are you currently able to sleep at night due to your symptoms?

☐ Sleep only with medication ☐ Awakened by pain ☐ Difficulty falling asleep ☐ No problem sleeping

Has this or something similar happened in the past?

○ Yes ○ No

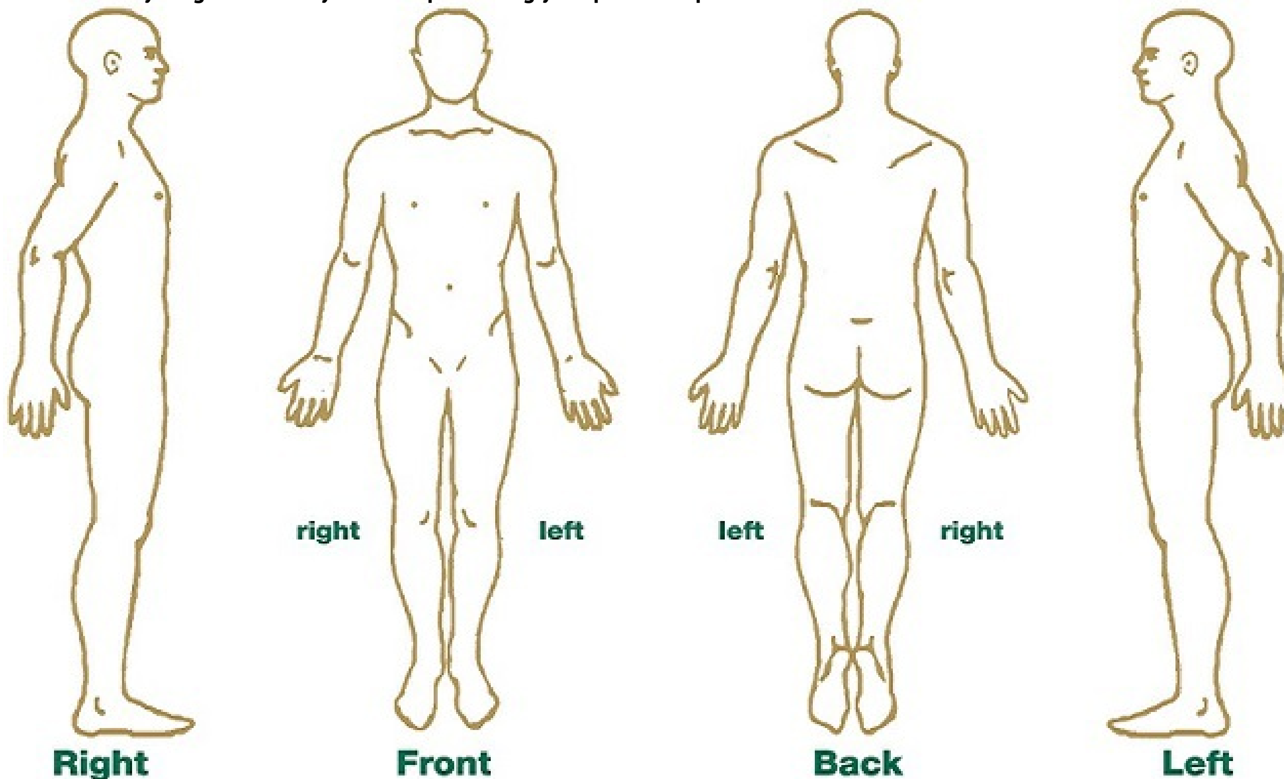
If you have experienced this problem in the past, when?

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?

Mark on this body diagram where you are experiencing your problems please.



List three positions or activities that make your symptoms worse:

When do your symptoms feel worse?

☐ After exercise ☐ Night ☐ Evening ☐ Afternoon ☐ Morning

List three positions or activities that make your symptoms better:

When do your symptoms feel best?

☐ After exercise ☐ Night ☐ Evening ☐ Afternoon ☐ Morning

Are your symptoms currently:

○ Come and go ○ Are constant ○ Are constant, but change with activity

List treatments or tests performed for this problem: (Chiropracitc, Injections, X-rays, MRI, blood work, etc.)

Has condition been treated by a Medical Physician?

○ Yes ○ No

Medical Physician Contact Info

Has condition been treated by a Chiropractor?

○ Yes ○ No

Chiropractor Contact Information

Have you ever had physical therapy before?

○ Yes ○ No

If yes, please tell us the name of that practice.

Were you happy with your previous physical therapy experience?

○ Yes ○ No

6. MEDICAL INFORMATION

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killer(including aspirin) ☐ Muscle relaxers ☐ Blood Thinners ☐ Insulin ☐ Stimulants
☐ Other(s)

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 with which you would like help?

○ Yes ○ Yes, but not today ○ No

During the past month have you been bothered by having little interest or pleasure in doing things?

○ Yes ○ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?

○ Yes ○ 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
☐ Pelvic inflammatory disease ☐ Bladder/urinary tract infection ☐ Other arthritic conditions
☐ Circulation problems ☐ Osteoporosis ☐ Multiple sclerosis ☐ Rheumatoid arthritis ☐ Bone or joint infection
☐ Pneumonia ☐ Blood clots ☐ Depression ☐ Sexually transmitted Disease ☐ Kidney Problems/Infection
☐ Arthritis ☐ Artificial Bones/Joints/Implants ☐ Lower Back Problems ☐ Chemotherapy ☐ Difficulty Breathing
☐ Tuberculosis ☐ Emphysema / Asthma ☐ Sinus Problems ☐ Fainting/Seizures/Epilepsy ☐ Ulcers / Colitisemia
☐ Severe / Frequent Headaches ☐ Rheumatic Fever ☐ Psychiatric Problems ☐ High/Low Blood Pressure
☐ Anemia ☐ Diabetes ☐ Frequent Neck Pain ☐ Eye problem/infection ☐ Shingles ☐ Congenital Heart Defect
☐ Mitral Valve Prolapse ☐ Artificial Valves ☐ Alcohol / Drug Abuse ☐ Hepatitis

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

List any surgeries or other conditions for which you have been hospitalized, including dates. (For example: Appendectomy June 2008, Knee replacement July 2011 or enter none.)

Are you under doctor ordered work restriction? if so, explain.

Please list anything that you may be allergic to:

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:

○ No ○ Yes

Date Since Starting Diet

For women: Are you taking?

○ Hormonal Replacement
○ Birth control pills

Are you nursing?

○ Yes ○ No

Are you Pregnant?

○ Yes ○ No

How long have you been pregnant?

How many children have you had?

We invite you to discuss with us any questions regarding our services. 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 account is not paid within 90 days of the date of service 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 any necessary services needed 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 and understand it is my responsibility to inform this office of any changes to the information I have provided.

Print your Name

____

Signature

____

Date

____