STRIDE PHYSIO, PLLC — Patient Registration

Name _____ Date _____
Last *First* *MI*

Address _____
Street *City* *State* *Zip*

Birth Date _____ Age _____ Sex: ❑ Female ❑ Male

Phone #s: Home _____ Work _____ Cell _____

E-mail _____ Contact Preference: ❑ Home ❑Work ❑ Cell ❑ E-mail

Employer/Occupation _____ Marital Status: ❑ Single ❑ Married ❑ Other

Referring Provider _____ Phone _____

Address of Referring Provider _____

Emergency Contact _____ Phone _____

INSURANCE INFORMATION – *Please provide insurance card for copying at 1st appointment*

Primary Insurance _____ Customer Service Phone _____

Subscribers Name _____ Birth Date _____

ID Number _____ Group Number _____

Patient's relationship to insured: ❑ self ❑ spouse ❑ child ❑ other Co-Pay amount _____

Secondary Insurance _____ Customer Service Phone _____

Subscribers Name _____ Birth Date _____

ID Number _____ Group Number _____

Patient's relationship to insured: ❑ self ❑ spouse ❑ child ❑ other

IF YOU HAD AN ACCIDENT, PLEASE COMPLETE THIS SECTION

Date of accident _____ How did it happen? ❑ Auto ❑ Work ❑ Other _____

Insurance Company _____ Claim Number _____

Address _____ Claims Adjuster _____ Phone _____

Attorney _____ Phone _____

Please read the following statements and sign below if you agree to the terms:

1. I authorize the release of any and all medical information that is necessary to process my claims or assist in my health care.
2. I have received a copy of the Notice of Privacy Practices and understand my rights to privacy and confidentiality regarding access to my medical records.
3. I authorize the payment of medical benefits for all claims filed to my insurance company. I am financially responsible for any balance.

Signed _____ Date _____

STRIDE PHYSIO, PLLC

Current Health Condition

Name:_____ Todays Date:_____

Date of Birth:_____ Age:_____ Height:_____ Weight:_____

Hand Dominance □ Right □ Left Referring Provider:_____

Occupation:_____ Employer:_____

Diagnosis or reason for seeking physical therapy:_____

_____

Date of onset (or approximately how long have you experienced symptoms):_____

Location of symptoms:_____

Have you had testing or imaging? □ Yes □ No If yes, what was done?_____

Have you had this problem before? □ Yes □ No If so when?_____

Was a surgery performed? If so when?_____

If you have pain, rate your pain level on a scale of 0-10 (0=no pain, 10=most extreme pain)

Current pain level_____ At worst_____ At best_____

How would you describe your pain: □ Ache □ Dull □ Sharp □ Burning □ Shooting
□ Deep □ Superficial □ Numbness □Tingling
□ Other:_____

Are your symptoms: □ Constant □ Intermittent □ Infrequent □ Variable

Is your pain worse at a certain time of day? □ Yes □ No
If yes, □ Worse at night □ Worse in morning □ Other?_____

Do you have difficulties getting to sleep due to pain? □ Yes □ No

Do you wake due to pain? □ Yes □ No If yes, # of timer per night_____

What activities are difficult to perform due to your condition?
□ Sitting □ Standing □ Squatting □ Walking □ Lifting
□ Reaching □ Dressing/Grooming □ Driving □ Stairs
□ Gripping/pinching □ Kneeling □ Lying down □ Work Tasks
□ Changing positions □ Other:_____

What household duties are you having difficulties performing?
□ Cooking □ Cleaning □ Vacuuming □ Laundry □ Yard Work
□ Grocery Shopping □ Other:_____

What activities make your pain/symptoms better?_____

What activities make your pain/symtoms worse?_____

Patient Name: _____

Previous Medical History

How would you classify your general health: ☐ Good ☐ Fair ☐ Poor

In terms of your general health, please check ALL that apply:

☐ Allergies
☐ Rheumatoid Arthritis
☐ Metal Implants
☐ Recent headaches
☐ Recent Vision Changes
☐ Sexual Dysfunction
☐ Osteoarthritis
☐ Heart Palpitations
☐ Chest Pain/Angina
☐ Stroke/TIA
☐ Physical Abnormalities
☐ Hypoglycemia
☐ Night pain
☐ Urine Leakage
☐ Kidney Problems
☐ Anemia
☐ Recent Fever
☐ Ringing in the ears
☐ Recent Nausea/vomiting
☐ Heart Attack
☐ Cancer
☐ Skin Abnormalities
☐ Osteoporosis
☐ Hernia
☐ Depression
☐ Surgeries
☐ Polio
☐ Intolerance to cold/heat
☐ Recent fractures
☐ Heart Disease
☐ Liver/Gallbladder problem
☐ Fibromyalgia
☐ Asthma/breathing Difficulties
☐ Seizures/Epilepsy
☐ Recent Dizziness/Fainting
☐ Change in Bowel/Bladder Function
☐ Pain with Cough/Sneeze
☐ Smoking History
☐ Pacemaker
☐ High/Low Blood Pressure
☐ Diabetes I or II
☐ Unexplained Weight Loss/Gain
☐ Pregnancy (current)
☐ Recent Unexplained Fatigue
☐ Numbness/Tingling
☐ Multiple sclerosis
☐ Other autoimmune conditions

Previous Surgeries (*please list all and date*)

1. _____
2. _____
3. _____
4. _____

Previous Injuries/Orthopedic Problems (*include date*)

1. _____
2. _____
3. _____
4. _____

Current Medications and/or Supplements and reason for taking

1. _____
2. _____
3. _____
4. _____

What hobbies, sports, fitness &/or recreational activities do you do regularly? _____

_____

What goals do you have for therapy? _____

_____

_____ _____

Signature *Date*