STRIDE PHYSIO, PLLC — Patient Registration

Name _____ Date _____
Last *First* *MI*

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

Birth Date _____ Age _____ Gender _____

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 _____

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PHYSIO

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?_____

Have you had a history of trauma? ☐Yes ☐No If yes, explain:_____

Was a surgery performed? If so when? _____

Have you had physical therapy or other treatments prior to current health condition? ☐Yes ☐No

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 times per night:_____

Client Name:_____

What household duties are you having difficulties performing?

☐ Cooking ☐ Cleaning ☐ Vacuuming ☐ Laundry ☐ Yard Work

☐ Grocery Shopping ☐ Other:_____

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 ☐ Laughing, Coughing, Sneezing ☐ Sexual Activity

☐ Other:_____

What activities make your pain/symptoms better?_____

What activities make your pain/symptoms worse?_____

How has lifestyle/quality of life been impacted by this problem?_____

_____

How would you rate your current level of stress? ☐ Low ☐ Medium ☐ High

How do you manage stress?_____

Previous Surgeries (*please list all and date*)

1._____

2._____

3._____

4._____

Previous Injuries/Orthopedic Problems/Motor Vehicle Collisions (*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*

Client Name:_____

General Medical/Health History

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

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

☐Alcohol/Drug Problems
☐Allergies
☐Anemia
☐Asthma/Breathing Difficulties
☐Cancer
Type:_____
☐Change in Bowel/Bladder Function
☐Chest Pain/Angina
☐Concussions
☐Depression
☐Diabetes I or II
☐Fibromyalgia
☐Heart Attack
☐Heart Disease
☐Heart Palpitations
☐Hepatitis
☐Hernia
☐High/Low Blood Pressure
☐HIV
☐Hypoglycemia
☐Intolerance to cold/heat
☐Jaw/Dental Issues
Explain:_____
☐Kidney Problems
☐Liver/Gallbladder problem
☐Metal Implants
☐Multiple sclerosis
☐Night pain
☐Numbness/Tingling
☐Osteoarthritis
☐Osteoporosis
☐Pacemaker
☐Pain with Cough/Sneeze
☐Physical Abnormalities
☐Polio
☐Recent Dizziness/Fainting
☐Recent Headaches
☐Recent Fever
☐Recent Fractures
☐Recent Nausea/vomiting
☐Recent Unexplained Fatigue
☐Recent Vision Changes
☐Rheumatoid Arthritis
☐Ringing in the ears
☐Seizures/Epilepsy
☐Skin Abnormalities
☐Smoking History
☐Stroke/TIA
☐Surgeries
☐Unexplained Weight Loss/Gain
☐Vertigo/Vestibular Disorders
☐Vision Changes
☐Other
_____

Pelvic Medical/Health History

In terms of your pelvic health, please check ALL that apply (complete only if applicable for care):

☐Coccyx Pain
☐Constipation
☐Currently Pregnant
☐Diarrhea
☐Endometriosis
☐Erectile Dysfunction
☐Fecal or Gas Incontinence
☐IBS
☐Painful Ejaculation
☐Painful Periods
☐Pelvic Pain
☐Physical or Sexual Abuse
☐Prostate Disorders
☐Sexual Dysfunction
☐Sexually Transmitted Disease
☐Shy Bladder
☐Urine Leakage
☐Vaginal Dryness

Menopause? ☐Yes ☐No If yes, date:_____

Date of Last Pelvic Exam:_____

Number of Pregnancies:_____

Number of Child Births:_____

Number of C-Sections:_____

Number of Vaginal Deliveries:_____

_____ _____

Signature *Date*