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_____

STRIDE PHYSIO

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*