

REGISTRATION FORM

Section I:	Patient Information	Date _____
Name: _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F _____	Birthdate _____
Address: _____	City: _____	State: _____ Zip _____
Phone (____) _____	Work Phone (____) _____	Cell Phone (____) _____
Social Security Number: _____	E-Mail _____	
Employer _____	Phone _____	Address _____
Whom may we thank for referring you? _____		
Person to contact in case of emergency _____		Phone _____
Primary Care Doctor _____		Phone Number _____

Section II	Responsible Party (If Different From Above)	
Relationship to Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other		
Name: _____	Relationship to Patient: _____	
Address: _____		
City: _____	State: _____	Zip: _____ Phone: (____) _____
Employer _____	Work Phone (____) _____	SSN# _____

Section III	Insurance Information	
Insurance Company _____	Claim/ID Number _____	
Ins Co Address: _____	Ins Co. Phone: _____	
Is this a WORK injury? _____	Is this from an AUTO accident? _____	Date of Injury _____
Claim Manager _____	Phone _____	

Section IV

Assignment and Release

I, the undersigned, do hereby assign directly to Valley Rehab Physical Therapy PS, Inc. / Troy Stang, MS, PT all medical benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges incurred, whether or not paid by insurance.** I hereby authorize release of all medical and other informational records which are necessary to process my medical insurance claims. I authorize the use of this signature on all my insurance submissions.

Signature of Insured /Responsible Person /Guardian

Date

Name: _____ Date: _____ Occupation _____

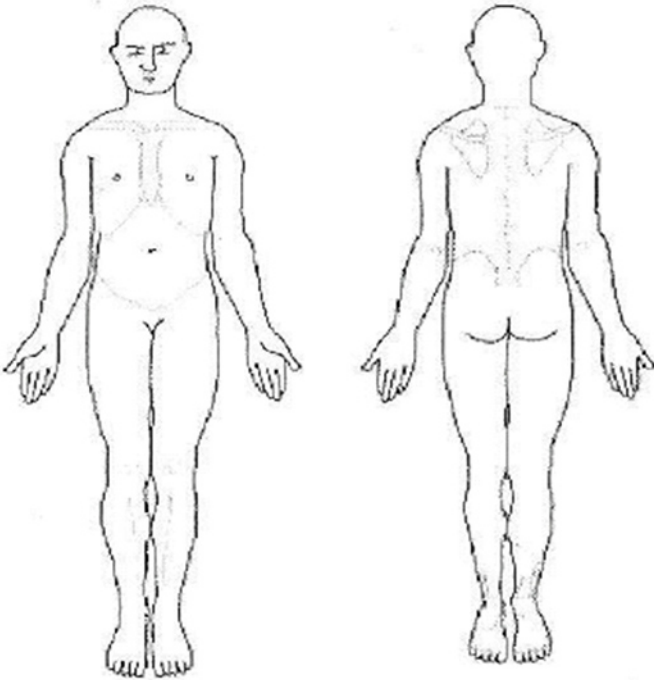
Referring Physician _____ Referred for: _____ Age: _____

To insure that you receive a complete and thorough evaluation, please provides us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

What are your symptoms?

Localize areas of **pain** or **abnormal** sensation on the body chart below (shade in where appropriate)



Pain Scale

On the following scale, mark a line to indicate your level of pain. One is low and 10 is high on the scale.

1 _____ 10

2. When did your symptoms begin? (Please indicate a specific date if possible) _____

3. Was the onset of this episode gradual or sudden? (Check one)
 gradual sudden

4. Which of the following best describes how your injury occurred? (If you condition is post-surgical please indicate as per original injury)

- | | |
|--|--|
| <input type="checkbox"/> lifting | <input type="checkbox"/> a blow to the head |
| <input type="checkbox"/> MVA (car accident) | <input type="checkbox"/> being hit by a ball |
| <input type="checkbox"/> a fall | <input type="checkbox"/> dental appointment |
| <input type="checkbox"/> overuse (cumulative trauma) | <input type="checkbox"/> throwing |
| <input type="checkbox"/> trauma | <input type="checkbox"/> an incident at work |
| <input type="checkbox"/> degenerative process | <input type="checkbox"/> unknown |
| <input type="checkbox"/> during recreation/sports | <input type="checkbox"/> per original injury |
| <input type="checkbox"/> running | <input type="checkbox"/> other |

5. Since the onset, are your symptoms getting: (Check one)
 better worse not changing

6. Have you had similar symptoms in the past?

Yes No

If "yes", have you had more than one episode?

Yes No

7. Nature of pain/symptoms (check all that apply)

- | | | |
|------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> sharp | <input type="checkbox"/> aching | <input type="checkbox"/> constant |
| <input type="checkbox"/> dull | <input type="checkbox"/> periodic | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> throbbing | <input type="checkbox"/> occasional | _____ |

8. As the day progresses do your symptoms: (Check one)

increase decrease stay the same

9. Does the pain wake you at night? Yes No

If "yes", is it present

while lying down only when changing positions both

10. Do you have pain/stiffness upon getting out of bed in the morning?

Yes No

11. In what position do you sleep? (Check all that apply)

- | | | |
|-------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> right side | <input type="checkbox"/> back | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> left side | <input type="checkbox"/> chair/recliner | |
| <input type="checkbox"/> stomach | <input type="checkbox"/> back, sides, stomach | |

12. Pillow

Foam Down Contoured

13. What aggravates your symptoms? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> sitting | <input type="checkbox"/> household activities |
| <input type="checkbox"/> going to/rising from sitting | including _____ |
| <input type="checkbox"/> lying down | <input type="checkbox"/> standing |
| <input type="checkbox"/> walking | <input type="checkbox"/> squatting |
| <input type="checkbox"/> up/down stairs | <input type="checkbox"/> sleep |
| <input type="checkbox"/> reaching overhead | <input type="checkbox"/> coughing/sneezing |
| <input type="checkbox"/> reaching in front of body | <input type="checkbox"/> taking a deep breath |
| <input type="checkbox"/> reaching behind back | <input type="checkbox"/> looking up/down |
| <input type="checkbox"/> reaching across body | <input type="checkbox"/> looking overhead |

14. Since the onset of your current symptoms have you had:

(Check all that apply)

- any difficulty with bowel bladder function
- fever/chills
- any numbness in the genital or anal area
- numbness
- any dizziness or fainting attacks
- weakness
- unexplained weight change
- night pain/sweats
- malaise (vague feeling of bodily discomfort)
- problems with vision/hearing
- none of the above

15. What relieves your symptoms? (Check all that apply)

- sitting
- heat
- cold
- stretching
- wearing a splint
- rest
- standing
- walking
- exercise
- massage
- medication
- nothing
- lying down
- other _____

16. Have you had any previous treatment for this condition? (Check all that apply)

- none
- medication (oral)
- joint manipulation
- exercise
- massage therapy
- traction
- bracing/taping
- injection into the spine
- injection into the skin/muscles
- physical therapy
- hypnosis
- biofeedback
- TENS unit
- acupuncture
- bed rest
- overnight hospitalization
- casting
- other _____

17. Have you had any of the following tests?

- none
 - x-rays
 - CT Scan
 - MRI
 - Arthrogram
 - Stress X-ray Test (Telos)
 - Bone Scan
 - Nerve Conduction S.
 - Fluoroscope
 - Vestibular
 - other _____
- Test Results: _____

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

- Cancer (type) _____
- Depression
- Stroke
- Kidney problems
- Thyroid problems
- Diabetes
- Multiple sclerosis
- Arthritis
- Head injury
- Stomach problems
- Parkinson's disease
- Infectious diseases (i.e. hepatitis, tuberculosis, etc.)
- Heart problems
- High blood pressure
- Lung problems
- Blood disorders
- Epilepsy/seizures
- Allergies
- Rheumatoid arthritis
- Osteoporosis
- Broken bone
- Circulation/vascular problems
- Other _____

Please list any recent/relevant past surgeries related to your current problem:

SURGERY

DATE

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATION

Are you currently taking any of the following over the counter medications?

- aspirin
- Tylenol
- corticosteroids
- antihistamines
- vitamins/mineral supplements _____
- Advil/ Motrin/ Ibuprofen
- glucosamine
- other _____

GENERAL HEALTH

How would you rate your general health?

- Excellent
- Good
- Average
- Fair
- Poor

Do you exercise outside of normal daily activities?

- 5+ days/wk
 - 3-4 days/wk
 - 1-2 days/wk
 - occasionally
 - zero
- Exercise, Sports/Recreation consisting of _____

Do you drink caffeinated beverages?

- No
 - Yes
- How many/much per day _____

Do you smoke?

- No
 - Yes
- Packs of cigarettes per day _____

What is your stress level?

- Low
- Medium
- High

Are you seeing any health care providers other than the physical therapist for this current condition? (Please list)

WORK HISTORY

Occupation _____

- employed full time
- employed part time
- self employed
- homemaker
- student
- retired
- unemployed
- other _____

Physical activities at work (check all that apply)

- sitting
- standing
- phone use
- repetitive lifting
- heavy lifting
- computer use
- heavy equipment operation
- driving
- other _____

Are you currently receiving or seeking disability for this condition? Yes No

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for or diagnosed with any of the following?

- Diabetes
- Heart Disease
- High blood pressure
- Stroke
- Cancer
- Arthritis
- Osteoporosis
- Psychological condition