Patient Registration

PATIENT INFORMATION

Name: _____ Date of birth: _____

Address: _____ Apt #_____

City: _____State: _____ Zip: _____

Phone Number: _____ Alt. Number: _____

Email: _____

Male ☐ Female ☐ Former Patient: Yes ☐ No ☐

Other than you doctor, how did you hear of Shelley A. Cooper PT?

_____

Have you received therapy within the calendar year? Yes ☐ No ☐ Where? _____

PHYSICIAN INFORMATION

Referring Physician: _____ Phone: _____

Address: _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Is your insurance an individual or group plan? _____

Name of policy holder: _____ Date of birth: _____

ID # _____ Group # _____

Secondary Insurance Company: _____

Name of policy holder: _____ Date of birth: _____

ID # _____ Group # _____

Have you verified your therapy benefits with your insurance? Yes ☐ No ☐
If not, we strongly encourage you to do so

Name:

Patient Medical History & Intake Questionnaire

Current Height: _____ Current Weight: _____

What problem(s) are you being treated for today? (Describe type and location)

_____

_____

Have you had any previous surgery? If yes, please explain

_____

Is the surgery related to your present illness or injury? Yes ☐ No ☐

MEDICAL HISTORY

Please check all that apply to you:

o High Blood Pressure	o Cardiac Conditions	o Heart Attack
o Circulation Problems	o Pacemaker	o Seizures
o Dizziness/lightheadedness	o Diabetes	o Nausea/vomiting
o Fractures	o Stroke	o Arthritis
o Kidney Problems	o Liver Problems	o Cancer
o Claustrophobia	o Nervous Disorders	o Vision Problems
o Sensitivity to heat	o Sensitivity to cold	o Speech Problems
o Metal Implants	o Change in bowl or bladder	o Shortness of breath
o Headaches	o Fever/chills/sweats	o Weight loss/gain
o Numbness/tingling	o Weakness/fatigue	o Difficulty maintaining balance and walking

If yes, please explain:

_____

_____

_____

Please list any allergies (i.e., latex, adhesives): _____

_____

Are you pregnant? Yes ☐ No ☐ If yes, how many weeks? _____

Name:

MEDICATIONS

Please provide names of all medications, vitamins, supplements, and over the counter drugs you are currently taking. **We can copy a detailed list if you have one.**

Medication Name

_____
_____
_____
_____
_____
_____
_____

List any medication(s) you are allergic to and your reaction:

SOCIAL HISTORY

Do you live alone? Yes ☐ No ☐

Do you use tobacco? Yes ☐ No ☐ if yes, indicate type, amount and frequency: _____

Alcohol intake and frequency: _____

Is there anything else we should know that is pertinent to your treatment? _____

_____

The above information I have supplied is complete, true and correct to the best of my knowledge.

Patient/Guardian Signature _____ Date _____