PATIENT REGISTRATION FORM

Patient's Name _____ **DOB** / / **Age** _____
(First) (Middle Initial) (Last)

Mailing Address _____**City**_____**State**_____**Zip**_____

Home Phone_____ **Cell**_____ **E-mail**_____

Employer Name_____ **Employer Phone**_____

Would you like to receive our newsletter via the email you provided? Yes ____ No____

What is your preferred method of appointment confirmations? (Please check one)

Text Message ____ E-mail____ Voicemail (Cell/home) _____ ☐ By checking this box you consent to us leaving a message at your preferred phone number.

Emergency Contact Name_____ **Relationship** _____ **Phone**_____

What made you choose Appalachian Physical Therapy for your care? _____

Are you a previous patient? _____ Have you been to a physical therapist or chiropractor in the past 12 months_____

Responsible Party Information:

Name_____ **Social Security Number**_____

Date of Birth _____/_____/_____ **Phone**_____

Address If Different From Patient _____

Insurance Policy Holder Information: (Only if different from patient information)

Name_____ **Date of Birth**____/____/____ **Phone**_____

Address If Different Than Patient _____

I desire that physical therapy services be provided to me and understand it will be my responsibility to pay for these services if my insurance does not pay or if my insurance benefits are paid to me inadvertently. I request that payment of authorized insurance benefits for services be preassigned to Appalachian Physical Therapy.

I understand that any balance remaining on my account after 60 days from the date of service is subject to interest charges at the rate of 2% per month. I understand I am responsible for all registered mail fees, court costs, and attorney fees incurred as a result of collection efforts on this account.

I understand that 24 hour notice is <u>required</u> to cancel or reschedule an appointment in order to avoid a $50.00 cancellation fee.

Patient signature_____ **Date**_____

Patient Representative/Legal Guardian, if applicable_____

<u>Privacy Practices</u>

Please review our Notice of Privacy Practices provided and check your desired option below

_____ I am aware of APT's Privacy Practices but <u>decline</u> a personal copy.
_____ I am aware of APT's Privacy Practices and <u>request</u> a personal copy.

Signature _____ **Date** _____

PATIENT MEDICAL HISTORY

Respiratory
- ☐ Allergies
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cough/hoarseness
- ☐ Dyspnea (difficulty breathing)
- ☐ Sinus problems
- ☐ Pneumonia
- ☐ Other: _____

Digestive
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dysphagia (difficulty swallowing)
- ☐ Fecal/bowel incontinence
- ☐ Food intolerance (dairy, gluten)
- ☐ Flatus (gas)
- ☐ IBS
- ☐ Reflux/GERD/heartburn
- ☐ Other: _____

Cutaneous-Thermoregulatory
- ☐ Skin allergies/sensitivities
- ☐ Dermatitis
- ☐ Eczema
- ☐ Psoriasis
- ☐ Itching/dry skin
- ☐ Hives
- ☐ Excess sweating
- ☐ Hot/cold flashes
- ☐ Other: _____

Urinary
- ☐ Dysuria (difficult or painful urine flow)
- ☐ Frequency/urgency
- ☐ Childhood bedwetting
- ☐ Incontinence
- ☐ Interstitial cystitis
- ☐ Organ prolapse
- ☐ Renal calculus (kidney stone)
- ☐ Urgency
- ☐ UTI
- ☐ Other: _____

Circulatory
- ☐ Cardiac problems
- ☐ Muscle cramping
- ☐ Hyper/hypotension (high or low blood pressure)
- ☐ Varicose/spider veins
- ☐ Swelling arms/legs/face
- ☐ Erectile dysfunction
- ☐ Raynaud's
- ☐ Restless legs
- ☐ Other _____

Immune/lymphatic
- ☐ Lymphedema
- ☐ Recurrent infections
- ☐ Allergies
- ☐ Autoimmune dysfunctions (RA, lupus, etc.)
- ☐ Other:_____

Hematopoietic (blood disorders)
- ☐ Anemia/erythropenia (low RBC)
- ☐ Iron deficiency
- ☐ Leukocytosis (elevated WBC)
- ☐ Leukopenia (low WBC)
- ☐ Thrombocytosis (elevated platelets)
- ☐ Other: _____

Endocrine
- ☐ Diabetes
- ☐ Dysmenorrhea
- ☐ Endometriosis
- ☐ Erectile dysfunction (also ACI)
- ☐ Hyperlipidemia (cholesterol)
- ☐ Infertility
- ☐ Thyroid dysfunction
- ☐ Uterine cysts/fibroids
- ☐ Other: _____

Adipose-Metabolic
- ☐ Overweight
- ☐ Underweight
- ☐ Unexplained weight loss (loss of 10lbs or more over the past 6 months)
- ☐ Unexplained weight gain (gain of 10lbs or more over the past 6 months)
- ☐ Other: _____

Head
- ☐ Photoreceptor – eye disturbances
- ☐ Mechanoreceptor – ear/vestibular disturbances, dizziness
- ☐ Chemoreceptor – nose / mouth disturbances
- ☐ Other: _____

Psychogenic
- ☐ Anxiety
- ☐ Depression
- ☐ Anorexia
- ☐ Bulimia
- ☐ Body dysmorphia
- ☐ Other: _____

Hospitalization in past year: _____

Testing (Xray, MRI, CT, US, Lab work, etc.): _____

Fractures: _____

Surgeries: _____

Significant accidents/trauma/FALLS: _____

Implanted devices (mesh, cosmetic implants, etc.): _____

Orthotics/Prosthetics (include heel lift, mouth guard, and other devices): _____

Regular Exercise Habits: _____

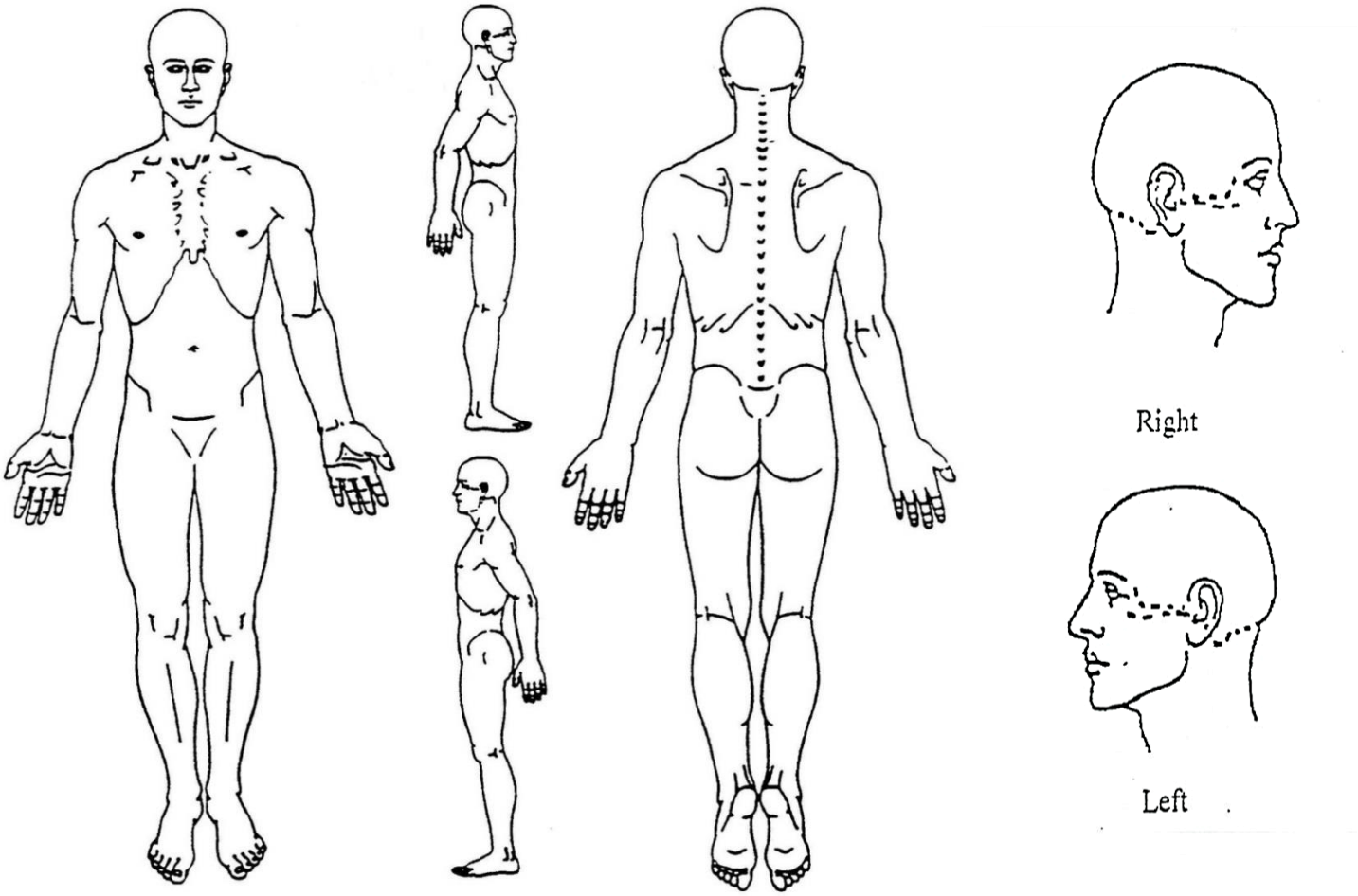
Pregnant: Y/N – How many weeks? _____

<u>Symptom Scale</u>: On a scale of 0-10 with 0 being none and 10 being the worst imaginable, please rate your primary complaint in the following manner

Right Now: _____ At Worst:_____ At Best:_____

On the diagram below please draw in your area(s) of complaint using the following symbols:

////// Pain, ache, stiff 0000 Numbness/tingling



<u>PT TO COMPLETE</u>:

Mechanism of Injury: (**T** = trauma; **?** = unknown/insidious; **sx** (surgical sights) sites; **fx** (fracture) sites.

Chronology/Timeline: (**L** end oldest problem – **R** newer; concomitant above, previous below)

Medication List for ________________________ Date______________

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	Dosage	Frequency	Method of Administration	Reason for Medication?
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:	
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:	
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:	
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:	
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:	
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:	
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:	
		❑ As Needed ❑ Once daily ❑ Twice daily ❑ Three times daily ❑ Other:	❑ Oral ❑ Sublingual ❑ Topical ❑ Subcutaneous injection ❑ Other:	