ACT PHYSICAL THERAPY

PATIENT REGISTRATION FORM

PATIENT INFORMATION

_____________________________ _____________________________________ ________________
Last name First name Middle initial

Address: ____

____ _________________________________ _________________
City State Zip

Mobile: ________________________ Home: ________________________________ Work: ______________________

Sex: Male _____Female ______ Race: ___________ Marital Status: Single______ Married______ Other______

Date of Birth: __________________________ WT. ___________ HT.____________ SS#______________________ _______

Referring Physician: ______________________________________ Diagnosis: ____________________________________

Allergies: ____

EMPLOYMENT INFORMATION

Name: ____

Address: ____

______________________________ _______________________________ ____________________________
City State Zip

Phone: ____ Extension: _________________________

EMERGENCY CONTACT INFORMATION

____ _________________________________ ______________________
Name of contact Relationship to patient Phone

Address: ____

___________________________________ ____________________________ ____________________
City State Zip

Current medications (Please list all even Advil)

Medication Name:	Dosage:	Frequency:

Surgical History (Please list all surgeries to date)

____

____

____

Did you have an accident or injury related to today's treatment: **YES / NO** Date of accident: ________________
If yes, please explain:

____

____

Is this a work-related injury? **YES / NO** Do you have a Work Comp Nurse Case Manager? **YES / NO**
Name: __________________________ Phone: _____________________

Have you received any therapy service ***this calendar year***? □ Yes (please mark below) □ No □ Inpatient Rehab/21 day stay □ Home Health □ Outpatient PT □ Speech Therapy □ Occupational Therapy
Could you be or are you pregnant? □ Yes □ No
Do you smoke? □ Yes □ No
Do you now have or have you ever had cancer? □ Yes □ No Please List:

Do you now have or have you ever had any of the following: (please check "yes" or "no" for all items)

CONDITION	YES	NO
Arthritis	□	□
Osteoporosis	□	□
High Blood Pressure	□	□
Heart Disease	□	□
Heart Attack	□	□
Pacemaker	□	□
Hypersensitivity to heat or cold	□	□
Stroke	□	□
Asthma	□	□
Shortness of Breath	□	□
Chronic Cough	□	□
Fainting Spells	□	□

CONDITION	YES	NO
Diabetes	□	□
Anemia	□	□
Vascular Disease	□	□
Ankle Swelling	□	□
Blood Clot (DVT)	□	□
Seizures/Epilepsy	□	□
Metal in body or Surgical Implants	□	□
Cancer/Tumor	□	□
Recent weight loss/gain	□	□
Current Infection(s)	□	□
Tuberculosis	□	□
Hepatitis	□	□

CONDITION	YES	NO
Thyroid Problem	□	□
Headache	□	□
Head Injury/Concussion	□	□
Hernia	□	□
Previous Fractures	□	□
Previous Surgeries	□	□
Kidney/Bladder Problems	□	□
Hearing Loss	□	□
Depression	□	□
Anxiety	□	□
Substance Abuse	□	□
Other:	□	□

PLEASE SIGN BELOW TO AUTHORIZE INSURANCE BILLING
I authorize that payment by my Insurance Company be made directly to ACT Physical Therapy on my behalf for services furnished to me. I authorize the release of any medical information about me to the Health Care Financing Administration and its agents and any information to determine benefits payable for related services. I further recognize that if the insurance company makes payment directly to me, the amount received is the property of ACT Physical Therapy and its agents to render treatment to me as deemed appropriate and as prescribed by my physician.

SIGNATURE: ____ **DATE:** __________________________________