

SporTherapy^{PC} Patient Registration Form

Today's Date _____

Appointment Date _____

RTD Date _____

Case # _____

Azle

Fossil Creek

NW Fort Worth

SW Fort Worth

Weatherford

Referring Doctor:	PCP:	Diagnosis:	ICD9:
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Patient Information

First Name	Middle Initial	Last Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number	Date of Birth	Home Phone #	Cell Phone #
Work #	Occupation		
Address	City	Zip Code	
Email address:			

In Case of Emergency

Name	Relation	Phone #	Phone #
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Chose clinic because or referred by: (Please check one)

- Doctor Close to Work Yellow Pages Internet
 Insurance Plan Family Member / Friend Other:

Injury Information

Type of Injury <input type="checkbox"/> Work <input type="checkbox"/> Auto Accident <input type="checkbox"/> Sports Injury <input type="checkbox"/> Other	Date of Injury/Accident	Surgery Date
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Payor Information

Primary Insurance Name	Phone #	ID/Subscriber #
Subscriber <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	Date of Birth	
Secondary Insurance Name	Phone #	ID/Subscriber #
Subscriber <input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Parent	Date of Birth	
Attorney Name	Phone #	Contact Name
Worker's Compensation or Auto Insurance	Adjuster	
Phone #	Ext	Claim #
Employer (Worker's Comp only)	Work Phone #	
Address	City	Zip Code

SporTherapy^{PC} Patient Medical History Form

Patient Name _____

Services for symptom(s) or injury: if yes:

- | | |
|---|---|
| <input type="checkbox"/> X-Ray | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> MRI | <input type="checkbox"/> Massage Therapy |
| <input type="checkbox"/> CT-Scan | <input type="checkbox"/> General Practitioner |
| <input type="checkbox"/> EMG | <input type="checkbox"/> Orthopedist |
| <input type="checkbox"/> Myelogram | <input type="checkbox"/> Emergency Room Care |
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Chiropractor |

Pain Level:

Current Lifestyle: if yes:

Circle One: (0 = no pain, 10 = worse pain imaginable)

At best? 0 1 2 3 4 5 6 7 8 9 10
At worst? 0 1 2 3 4 5 6 7 8 9 10
Currently? 0 1 2 3 4 5 6 7 8 9 10

- Smoke?
 Consume alcohol?
 Pregnant?

Medication Allergies: if yes:

- | | |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Adhesives | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Morphine |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> NSAID's |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Sulfa |
| | <input type="checkbox"/> Tetracycline |

Other:

List Current Medications:

List past surgeries with dates:

Current Symptoms: if yes:

- | | |
|--|---|
| <input type="checkbox"/> Bowel or Bladder Trouble / Problems | <input type="checkbox"/> Shortness of Breath or Chest Pains |
| <input type="checkbox"/> Dizziness or Fainting | <input type="checkbox"/> Vision or Hearing Difficulties |
| <input type="checkbox"/> Energy Loss | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Nausea / Vomiting | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Numbness | |

Other:

Medical History: Have you ever had, or do you have any of the following? if yes:

- | | |
|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis / Swollen Joints | <input type="checkbox"/> Infectious Diseases |
| <input type="checkbox"/> Asthma, Bronchitis or Emphysema | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Cancer or chemotherapy / radiation | <input type="checkbox"/> Mental Illness (i.e. bipolar, etc) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Headaches, Frequent or Severe | <input type="checkbox"/> Thyroid / Goiter |
| <input type="checkbox"/> Heart Attack / Heart Surgery | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Heart Disease or Angina | <input type="checkbox"/> Pins in Joints or Metal Implants |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Injury / Surgery (Circle any that apply) |
| <input type="checkbox"/> Hernia | |

Other:

Ankle / Back / Elbow / Foot / Hand /
Knee / Neck / Shoulder