*SporTherapy*PC Patient Registration Form

Today's Date _____
Appointment Date _____
RTD Date _____
Case # _____

SW Fort Worth ☐ NW Fort Worth ☐ Azle ☐ Fossil Creek ☐ Weatherford ☐

Referral Information

Chose clinic or referred to clinic by: (please check one)
☐ Close to Work ☐ Doctor ☐ Family Member / Friend ☐ Insurance Plan ☐ Internet ☐ Yellow Pages ☐ Other:

Referred to physical therapy for: (please check one) ☐ Chronic Pain ☐ Work Injury ☐ Auto Accident ☐ Sports Injury ☐ Other:	Injury Date	Surgery? ☐ Yes ☐ No Date:
Diagnosis:	ICD9:	
Referring Doctor:	PCP:	

Patient Information

First Name	Middle Initial	Last Name	Nickname
Gender ☐ Male ☐ Female		Date of Birth	Social Security Number
Mailing Address		City	Zip Code
Home #	Work #	Cell #	
Occupation		Email address:	

Emergency Information

Name	Relation	Phone #

Payor Information

Primary Insurance Name	Phone #	ID/Subscriber #
Subscriber ☐ Patient ☐ Spouse ☐ Parent		Date of Birth
Secondary Insurance Name	Phone #	ID/Subscriber #
Subscriber ☐ Patient ☐ Spouse ☐ 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 current symptom(s) or injury: ☑ if yes:

- ❑ X-Ray
- ❑ MRI
- ❑ CT-Scan
- ❑ EMG
- ❑ Myelogram
- ❑ Physical Therapy
- ❑ Occupational Therapy
- ❑ Massage Therapy
- ❑ General Practitioner
- ❑ Orthopedist
- ❑ Emergency Room Care
- ❑ Chiropractor

Pain Level:

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

Current Lifestyle: ☑ if yes:

- ❑ Smoke?
- ❑ Consume alcohol?
- ❑ Pregnant?

Medication Allergies: ☑ if yes:

- ❑ Adhesives
- ❑ Aspirin
- ❑ Codeine
- ❑ Demerol
- ❑ Iodine
- ❑ Latex
- ❑ Morphine
- ❑ NSAID's
- ❑ Penicillin
- ❑ Sulfa
- ❑ Tetracycline

Other:
_____
_____
_____
_____

List Current Medications:

_____
_____
_____
_____
_____

List past surgeries with dates:

_____
_____
_____
_____
_____

Current Symptoms: ☑ if yes:

- ❑ Bowel or Bladder Trouble / Problems
- ❑ Dizziness or Fainting
- ❑ Energy Loss
- ❑ Nausea / Vomiting
- ❑ Numbness
- ❑ Shortness of Breath or Chest Pains
- ❑ Vision or Hearing Difficulties
- ❑ Weakness
- ❑ Weight Loss

Other:
_____
_____
_____
_____

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

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

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

Other:
_____
_____
_____
_____
_____
_____
_____
_____
_____