NEW PATIENT REGISTRATION

Personal Information

Last Name: _____
First Name: _____
Address: _____ APT#_____
City:_____ State: _____ Zip: _____
Home #:(_____)_____ Work #:(_____)_____
Cell #:(_____)_____ Fax #: (_____)_____
E-mail: _____
Appointment Reminder: Email ☐ or Text ☐ Carrier:_____
Marital Status: M☐ S☐ W☐
Date Of Birth: _____ Sex: ☐ M ☐F
Referring Physician: _____

Employment Information

Employer: _____
Employer Address: _____
Responsible Party:☐Self/☐Other (If other) Name:_____ _____
Address: _____ Phone: _____

Insurance Information

Name of Insured: _____
SS# of Insured: _____
Insurance Carrier: _____ Phone: _____
Policy #: _____ Group #: _____

In Case of Emergency

Name: _____
Relationship: _____
Phone: _____

PATIENT MEDICAL HISTORY FORM

Height _____
Weight _____

Name: _____ Age:_____

Current Concern/Problem:_____
Onset (when did your problem begin?):_____
Is your condition related to an accident? YES [ ] NO [ ]

Have you ever been diagnosed with any of the following conditions: Circle YES or NO

(If YES, please explain in the space provided below)

Cancer	**☐ YES ☐ NO**	**Anemia**	**☐ YES ☐ NO**
Thyroid Conditions	**☐ YES ☐ NO**	**Stroke**	**☐ YES ☐ NO**
Pacemaker	**☐ YES ☐ NO**	**DVT**	**☐ YES ☐ NO**
High Blood Pressure	**☐ YES ☐ NO**	**Migraines**	**☐ YES ☐ NO**
Heart Attack	**☐ YES ☐ NO**	**Osteoporosis**	**☐ YES ☐ NO**
Heart Condition	**☐ YES ☐ NO**	**Diabetes**	**☐ YES ☐ NO**
Fever/Night Sweats	**☐ YES ☐ NO**	**Dizziness**	**☐ YES ☐ NO**
Deep Venous Thrombosis	**☐ YES ☐ NO**	**Pneumonia**	**☐ YES ☐ NO**
Metal Implants	**☐ YES ☐ NO**	**Asthma**	**☐ YES ☐ NO**
Circulation Problems	**☐ YES ☐ NO**	**Seizures**	**☐ YES ☐ NO**
Osteoarthritis	**☐ YES ☐ NO**	**Other**	**☐ YES ☐ NO**
Rheumatoid Arthritis	**☐ YES ☐ NO**		

Please describe YES answers:_____

_____

_____

Medications you are currently taking (including over-the counter medications):

_____

_____

_____

Have you had Physical Therapy before? If so, please describe type and results of treatment_____

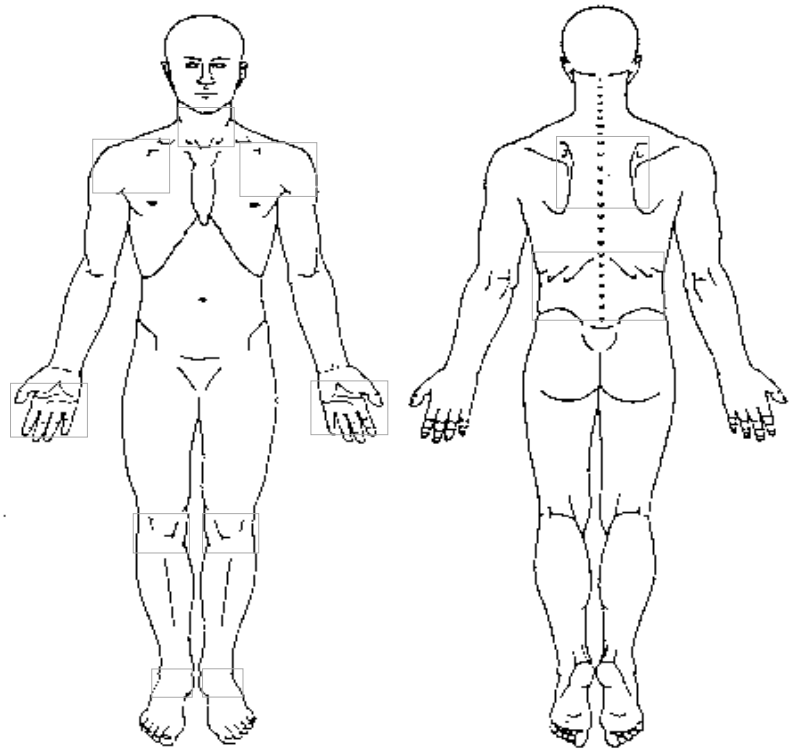
Duffy-Rath Questionnaire©

Name:_____ **Date:**_____ **Visit #:**_____

The following information lets us know how you are doing **TODAY!** Please complete this questionnaire at each visit. We understand that by limiting your responses to how you are today, we may be catching you on a particularly good or bad day **(PLEASE COMPLETE BOTH SIDES OF QUESTIONNAIRE)**.

Draw on the figure below where you feel **pain TODAY.**

Use '***X***' marks to show where you feel **numbness, tingling or pins and needles TODAY.**



Circle the number that describes your symptoms TODAY.

NECK/ARM

1. How bad is your **neck / upper back** pain?
   0-No Pain
2. How **frequent** is your **neck / upper back** pain?
   0-Never There
3. How bad is your **arm** pain?
   0-No Pain
4. How **frequent** is your **arm** pain?
   0-Never There
5. How bad is your **numbness/tingling**?
   0-No Pain
6. How **frequent** is your **numbness/tingling**?
   0-Never There

LOWER BACK/LEG

1. How bad is your **back** pain?
   0-No Pain
2. How **frequent** is your **back** pain?
   0-Never There
3. How bad is your **leg** pain?
   0-No Pain
4. How **frequent** is your **leg** pain?
   0-Never There
5. How bad is your **numbness/tingling**?
   0-No Pain
6. How **frequent** is your **numbness/tingling**?
   0-Never There

Functional Status Questionnaire

Indicate how you are doing by **CIRCLING** the number that best describes your ability **TODAY.** Please complete this questionnaire at each visit. We understand that by limiting your responses to how you are doing today, we may be catching you on a particularly good or bad day.

1. Rate Your Ability to Sit:

0-Completely able to do

2. Rate Your Ability to Stand:

0-Completely able to do

3. Rate Your Ability to Walk:

0-Completely able to do

4. Rate Your Ability to Bend Forwards:

0-Completely able to do

5. Rate Your Ability to Lift and Carry:

0-Completely able to do

6. Rate Your Ability to Participate in Your Normal Sport or Recreational Activities :

0-Completely able to do

7. Rate Your Ability to Work:

0-Completely able to do

8. Rate Your Ability to have Sexual Relations:

0-Completely able to do

9. Rate Your Ability to Sleep:

0-Completely able to do

10. Rate Your Overall Ability to Perform Your Normal Daily Activities:

0-Completely able to do