Champion Physical Therapy

Patient Registration Form

First Name _____ MI ___ Last Name _____ Title _____

Date of Birth _____ Social Security # _____ Gender ☐ Male ☐ Female

Mailing Address _____

_____

_____

Physical Address _____

_____

_____ Driver's Lic # _____

		OK To Call	Best Time To Call
Home Phone	_____	☐	_____
Work Phone	_____	☐	_____
Cell Phone	_____	☐	_____

Marital Status
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Unknown

Employment Status
- ☐ Full-Time
- ☐ Part-Time
- ☐ Self Employed
- ☐ Active Duty
- ☐ Disabled
- ☐ None
- ☐ Student
- ☐ Retired
- ☐ Unknown

Email Address _____ Interpretor Required? ☐ Language _____

Patient Employer _____ Spouses Employer _____

Address _____ Address _____

_____ _____

Phone _____ Phone _____

Occupation _____ Occupation _____

How did you hear about us?
- ☐ Physician
- ☐ Employer
- ☐ Case Manager
- ☐ Former Patient
- ☐ Adjustor
- ☐ School
- ☐ Hospital
- ☐ Cross Referral
- ☐ Friend - Word of Mouth
- ☐ Attorney
- ☐ Self
- ☐ Screens - Open Houses
- ☐ Marketing Ad - Print
- ☐ Marketing Ad - TV
- ☐ Marketing Ad - Billboard
- ☐ Marketing Ad - Direct Mail - Email

Specify: _____

Attorney Name _____ Phone _____

Address _____

_____

Emergency Contact _____ Phone _____

Address _____

_____

Prescribing MD _____ Phone _____

Do you have a written prescription? ☐ Yes ☐ No

Body Part / Region _____ Date of Injury _____

Was this injury the result of an accident? ☐ Work ☐ Auto ☐ Other ☐ None

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize the release of any and all information to my insurance company or other appropriate party, as required, pertaining to treatment rendered to me by Champion Physical Therapy. Further, I authorize Champion Physical Therapy to obtain needed information from my physician, employer or insurance company.

CONSENT TO TREATMENT & FINANCIAL RESPONSIBILITY

I hereby consent to the treatment as prescribed by my physician and provided by Champion Physical Therapy, its employees, or representative. I understand that I am ultimately responsible for charges related to my treatment. All accounts are due and payable upon receipt of the bill.

NOTICE OF INFORMATION PRACTICES

I acknowledge that I have been shown the posted Notice of Privacy Practices by Champion Physical Therapy.

_____ _____

Signature of Patient Date

MEDICAL HISTORY FORM

Area of Symptoms: _____ Age: _____

Date of Onset: _____

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and your safety. Thank you.

Any known results of recent x-rays or tests: _____

_____

Chronic Conditions: Yes ☐ No ☐ If yes, please list: _____

_____

Allergies: Yes ☐ No ☐ If yes, please list: _____

_____

List surgeries and dates: _____

Medications: Yes ☐ No ☐ If yes, please list: _____

_____

Do you have or have you had any of the following:

Cancer	Yes ☐	No ☐	High Blood Pressure	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Metal Implants	Yes ☐	No ☐
Epilepsy or Seizures	Yes ☐	No ☐	Respiratory Problems	Yes ☐	No ☐
Heart Disease	Yes ☐	No ☐	Are you pregnant?	Yes ☐	No ☐

1. How would you rate your ability to perform routine daily activities:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Unable to perform No Problems

2. How would you rate your ability to perform the activities associated with your job:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Unable to perform No Problems

3. How would you rate your current pain:

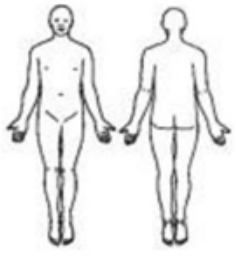
0 1 2 3 4 5 6 7 8 9 10

None Emergency Room

4. How many days since your current injury? ☐ 0-30 days ☐ 31-90 days ☐ 90+ days

Please draw your pain on the body to the right using the following symbols:

///	Stabbing pain
xxx	Burning
ooo	Pins and needles
===	Numbness



Patient Signature _____ Date _____