

Cornerstone Physical Therapy

REGISTRATION

PATIENT INFORMATION

NAME(FIRST) _____ (MI): _____ (LAST): _____

SSN: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

PHONE #: _____ SEX: M / F MARITAL STATUS: M / S / W / D / SEP

SPOUSES NAME: _____ DO YOU HAVE CHILDREN? IF YES, HOW MANY? _____

MAY WE LEAVE MESSAGES ON YOUR ANSWERING MACHINE? YES NO
MAY WE CONTACT YOU AT WORK? YES NO

EMPLOYER: _____ FOR HOW LONG? _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: _____ EXT.#: _____

EMERGENCY CONTACT: _____ PHONE #: _____

REFERRING MEDICAL DOCTOR/OFFICE: _____

IF YOU HAVE HAD AN ACCIDENT, IS IT: WORK RELATED? Y / N AUTO RELATED? Y / N N/A

IF CLAIM IS WORK RELATED, WHO MAY WE CONTACT AT YOUR WORK TO VERIFY? _____

GUARANTOR/INSURANCE INFORMATION

(COMPLETE ONLY IF DIFFERENT FROM ABOVE)

NAME: _____ RELATIONSHIP: _____ PHONE: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

SSN: _____ EMPLOYER: _____

ADDRESS: _____

AUTHORIZATION TO PAY BENEFITS TO MEDICAL PROVIDER: I hereby authorize payment directly to the Therapist/Cornerstone Physical Therapy of the Medical Benefits, realizing I am responsible to pay for non-covered services.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Cornerstone Physical Therapy to release any information acquired in the course of treatment to my primary care physician and/or referring physician and to the Insurance Companies to process by claims.

I have been presented with a copy of the privacy policy of Cornerstone Physical Therapy.

PATIENT OR GUARANTOR SIGNATURE

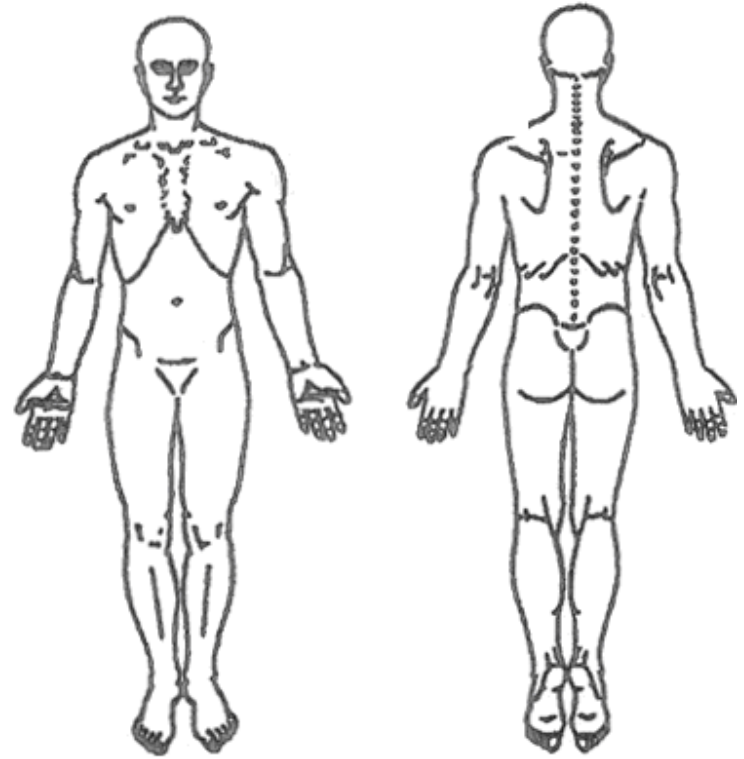
DATE

Pain and Symptom Status Report

Name: _____

Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



- | | | |
|---|------------------------------|--------------------------------|
| Ache
MMM
M | Burning

--- | Numbness
OOOO
OOO |
| Pins and Needles
□□□□□□□□
□□□□□□□□ | Stabbing
///// | Other
xxxx
xxx |

Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it
Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it
Please circle on the scale below to indicate your <u>WORST</u> level of pain:												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it

Additional Comments _____

MEDICAL HISTORY

HEIGHT: _____

WEIGHT: _____

PLEASE LIST ANY MEDICATIONS THAT YOU ARE PRESENTLY TAKING AND THE REASON YOU ARE TAKING THEM:

ARE YOU ALLERGIC TO ANY MEDICATIONS? YES NO

IF YES, PLEASE LIST: _____

EMERGENCY CONTACT: _____ PHONE: _____

PLEASE CHECK IF YOU HAVE A PERSONAL HISTORY OF ANY OF THE FOLLOWING CONDITIONS:

- | | | |
|---|--|--|
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> BULEMIA | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> IRREGULAR HEARTBEAT | <input type="checkbox"/> CANCER | <input type="checkbox"/> COLON DISEASE |
| <input type="checkbox"/> CHEST PAIN WITH EXERTION | <input type="checkbox"/> KIDNEY DISORDER | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> GALLBLADDER DISORDER | |
| <input type="checkbox"/> LIGHT HEADEDNESS OR FAINTING | <input type="checkbox"/> ARTHRITIS | |
| <input type="checkbox"/> EXERCISE INDUCED ASTHMA | <input type="checkbox"/> BACK PAIN: UPPER | |
| <input type="checkbox"/> SHORTNESS OF BREATH | MIDDLE | |
| <input type="checkbox"/> HIATAL HERNIA | LOWER | |
| <input type="checkbox"/> HYPOGLYCEMIA | <input type="checkbox"/> JOINT PAIN: WHERE? _____ | |

OTHER: _____

DO YOU TOBACCO PRODUCTS? YES NO _____

HAVE YOU HAD EXPOSURE TO OR BEEN DIAGNOSED WITH TUBERCULOSIS? NO YES: _____

PLEASE PROVIDE AN EXPLANATION FOR ANY ITEMS CHECKED ABOVE: _____

**** IF YOU CHECKED ANY OF THE ABOVE CONDITIONS, HAS YOUR DOCTOR RELEASED YOU TO PERFORM EXERCISE? YES NO**

TO THE BEST OF MY KNOWLEDGE, ALL OF THE ABOVE INFORMATION IS TRUE AND ACCURATE.

PATIENT/GUARDIAN SIGNATURE

DATE