Patient Registration Form

West Portland
Physical Therapy
Clinic LLC

Patient Information			
		Account # :	
Name:		Date of Birth:	
Address:		Primary Phone:	
Please indicate the best number for your appointment reminder calls: ☐ Home ☐ Cell ☐ Text		Alternate Phone:	
Email:	May we contact you via email? Yes No		

Employer Information			
Employer:		Employer Phone:	

Guarantor Information			
Guarantor Name:		Guarantor Phone:	
Guarantor Address: (If different from patient):			

Emergency Contact Information			
Emergency Contact:		Emergency Contact Phone:	
Relationship:			

Injury Information:

Date of Injury:	Onset Date:	Work Related?	Auto Related	Account Type:
			- State -	-
Description of Injury:				
Is this injury related to a Motor Vehicle Accident? Yes No		Is this injury related to a Workers Comp claim? Yes No		

Physician Information			
Referring Physician:		Phone:	
Primary Physician:		Phone:	
Other Physician:		Phone:	

Primary Policy Information

Name/Address of Insurance		Policy / ID #	Group #		Name of Insured	Insured DOB
					Effective Dates	-

Secondary Policy Information

Name/Address of Insurance		Policy / ID #	Group #		Name of Insured	Insured DOB
					Effective Dates	-

I certify that all of the information provided herein is true and correct.

Signature: _____ Date: _____

Therapist Initials: _____

Pain Assessment

West Portland
Physical Therapy
Clinic LLC

Name:		Date of Birth:	

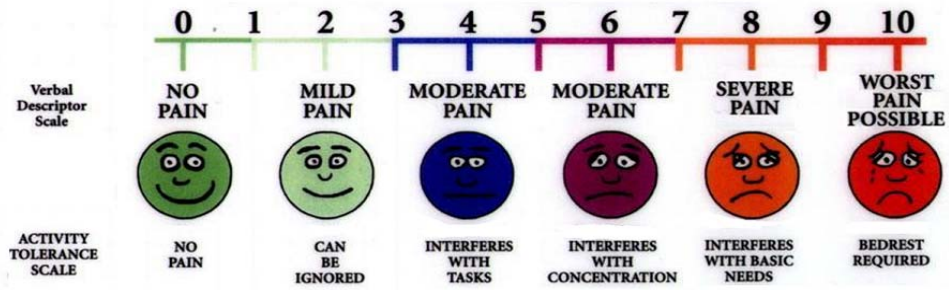
It is very important for us to stay in touch with your physician. Please provide us with the date of your next appointment.

Next Physician Appointment: _____ Today's Date: _____

If you do not have an appointment set, please let us know when you have made your next appointment.

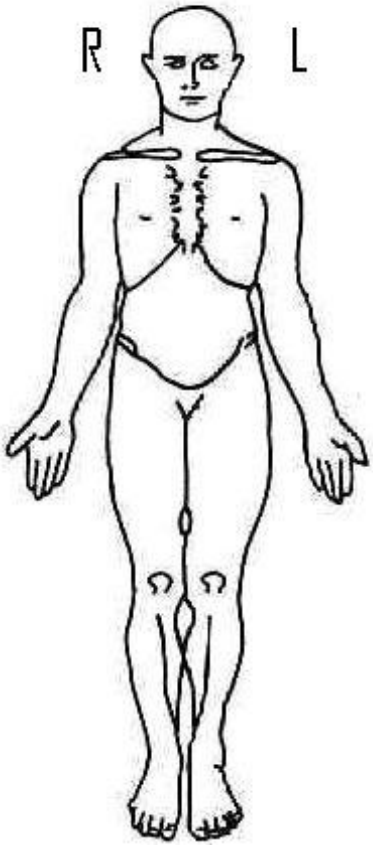
UNIVERSAL PAIN ASSESSMENT TOOL

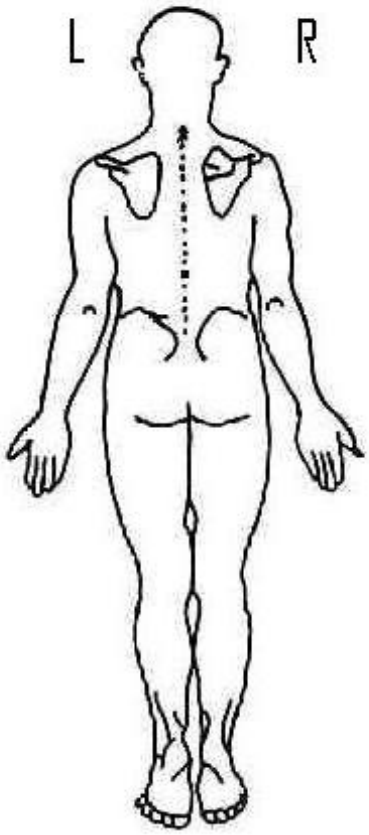
Please Circle the Description of your pain in the past week. Circle both your best level of pain and your worst level of pain.



WHERE IS YOUR PAIN?

Please mark the area of your pain on the drawings below.





Medical History

West Portland
Physical Therapy
Clinic LLC

Name:		Date of Birth:	

Occupation: _____ Age: _____

Referring Physician: Primary Physician:

Have you had surgery for this injury? Yes _____ No _____ Type _____ Date:_____

Please list current medications:

Anti-inflammatories: _____ Muscle Relaxers: _____

Pain Medication: _____ Other: _____

Have you seen other practitioners or had any of the following treatments for your current complaint?

Orthopedist	_____	Massage Therapy	____
Neurologist	_____	Acupuncture	____
Physical Therapist	_____	X-Rays	____
Chiropractor	_____	MRI	____
Naturopath	_____	Other	____

Do you now have or have you ever had any of the following conditions?

	Now	Past		Now	Past
Asthmas, Bronchitis, or Emphysema	____	____	Diabetes	____	____
Shortness of Breath / Chest Pain	____	____	Gout	____	____
Heart Disease or Angina	____	____	Anemia	____	____
Heart Attack or Surgery	____	____	Hernia	____	____
High Blood Pressure	____	____	Neck Injury	____	____
Do You Have a Pacemaker?	____	____	Back Injury	____	____
Blood Clot or Emboli	____	____	Knee Injury	____	____
Infectious Diseases	____	____	Hand or Wrist Injury	____	____
Numbness or Tingling	____	____	Elbow Injury	____	____
Dizziness or Fainting	____	____	Shoulder Injury	____	____
Metal in Body or Surgical Implants	____	____	Ankle or Foot Injury	____	____
Joint Replacement	____	____	Do you smoke?	____	____
Sleeping Problems or Difficulties	____	____	Are you currently pregnant?	____	
Bowel or Bladder Problems	____	____	Are you allergic to latex?	____	
Emotional / Psychological Problem	____	____	Unexplained Weight Loss / Gain	____	
Osteoporosis	____	____	Is your pain relieved by rest or bed rest?	____	
Arthritis (Rheumatoid)	____	____	Do you have a history of cancer?	____	
Stroke / TIA	____	____	(especially breast, prostate, or lung cancer)		

Please list any past surgeries that you have had and the date:

_____

Are you aware of your current diagnosis? Yes ____ No ____

What are your expectations and goals of treatment?

_____

Signature: _____ Date: _____