PURSUIT
PHYSICAL THERAPY

PATIENT REGISTRATION
Confidential

Please Print Legibly

Name _____ (First Name / MI / Last Name)
Address 1 _____
Address 2 _____
City _____ State _____
Zip _____
Home Phone _____
Mobile Phone _____
Email _____

Date of Birth _____ Age _____
Gender ○ Male ○ Female
Social Security # _____
Marital Status ○ Single ○ Divorced ○ Married ○ Widowed
Employer _____
Occupation _____
Work Phone _____

REFERRAL INFORMATION

Diagnosis _____
Referring Physician _____ Phone _____
Primary Care Physician _____ Phone _____
Do you give us permission to give information to your Primary Care Physician? ○ Yes ○ No
Are you currently receiving services from a home health Agency? ○ Yes ○ No
How did you hear about Pursuit Physical Therapy? _____

INSURANCE INFORMATION

Insurance Carrier _____
City _____
State _____
Phone _____
Fax _____
Insured's Name _____
Member # _____
Employer Name _____
Group # _____
Is this a Work Injury? ○ Yes ○ No
If "Yes", Date of Injury _____
Case Manager Name _____

EMERGENCY CONTACT

Name _____
Relationship _____
Phone _____

☐ *I have been given my insurance benefits and fully understand my responsibility. I understand that I am encouraged to contact my insurance company to verify that the benefits quoted to Pursuit Physical Therapy are correct. Pursuit Physical Therapy is not responsible for misquoted insurance benefits.*

For Office Use Only

	Details
☐ Insurance Verified	
☐ Deductible	_____
☐ Co-Pay	_____
☐ Co-Insurance	_____

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CURRENT CONDITION Height _____ Weight _____

Briefly describe why you are here? _____

What caused it? _____ When did it start? _____

What makes it better? _____

What makes it worse? _____

What percentage of day does it bother you? ○ 0% ○ 25% ○ 50% ○ 75% ○ 100%

What activities are limited by it? _____

List other health professionals seen: _____

What tests have you had for it? ☐ X-ray ☐ MRI ☐ CT ☐ EMG/NCV ☐ Other _____

Where? _____

Have you had 2 or more falls in the past year or a fall with injury in the past year? ○ Yes ○ No

PERSONAL HEALTH HISTORY
GENERAL CURRENT CONDITIONS

(Please read all and check all that apply to you)

Recent
- ☐ Accident
- ☐ Surgery
- ☐ Fall
- ☐ Whiplash
- ☐ Blow to Head

- ☐ Muscle Spasms
- ☐ Numbness / Tingling
- ☐ Radiating Pain
- ☐ Restricted Movement
- ☐ Spinal Disorder
- ☐ Shoulder / Arm / Hand problems
- ☐ Hip / Leg / Foot problems
- ☐ Jaw / Mouth problems

- ☐ Head Aches
- ☐ Migraines
- ☐ Depression
- ☐ Anxiety
- ☐ Dizziness
- ☐ Vision problems
- ☐ Nausea
- ☐ Sleep problems

- ☐ Asthma / Breathing problems
- ☐ High Blood Pressure
- ☐ Convulsions / Epilepsy
- ☐ Heartburn / Acid Reflux
- ☐ Digestive problems
- ☐ Menstrual problems
- ☐ Sinus problems
- ☐ Stress problems

DIAGNOSED CONDITIONS

- ☐ Born with Bone / Joint Disorder
- ☐ Degenerative Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Compression Fracture
- ☐ Heart Attack / Disorder
- ☐ History of Stroke or Aneurysm
- ☐ Cancer
- ☐ Diabetes
- ☐ Multiple Sclerosis

- ☐ Gout
- ☐ Lupus
- ☐ Tuberculosis
- ☐ Hepatitis B or HIV Infection
- ☐ Thyroid or Hormone Disorder
- ☐ Osteoporosis / Osteopenia
- ☐ Immune Suppression Treatment / Disorder from chemotherapy, organ transplant, drugs, etc.
- ☐ 3+ months Steroid Medication or Intravenous drugs (past or present)

DESCRIBE YOUR HABITS

Alcohol (amount per day) _____

Smoke (amount per day) _____

Exercise (hours per week) _____

Rate Your Diet ○ Good ○ Fair ○ Poor

Other Conditions _____

_____

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SPECIFIC BODY PAIN

- ☐ Neck pain with difficulty swallowing
- ☐ Extreme neck stiffness with pain or "electric shocks" in arms or legs when moving neck
- ☐ Numbness or tingling of hands or feet or radiating pain
- ☐ Leg pain with exercise
- ☐ Numbness of inner thighs
- ☐ Back pain with urinary problems
- ☐ Severe pain that interrupts sleep
- ☐ Constant pain that does not improve by changing positions or lying down

SPECIFIC CURRENT CONDITIONS

- ☐ Poor balance when walking or standing
- ☐ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ☐ Memory loss after injury
- ☐ Recent unexplained weight loss
- ☐ Recent progressive muscle weakness or shaking
- ☐ Recent or current fever over 102°F
- ☐ Loss of bowel or bladder control
- ☐ Pregnant Date of Last Period _____

PAIN RATING	No Hurt		Hurts little bit		Hurts little more		Hurts even more		Hurts whole lot		Hurts worse
Rate your pain at its...											
Least:	○	○	○	○	○	○	○	○	○	○	○
Most:	○	○	○	○	○	○	○	○	○	○	○
Average:	○	○	○	○	○	○	○	○	○	○	○
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Mild Pain Annoying
Pain is present but does not limit activity

Nagging Pain Uncomfortable
Can do most activities with rest periods

Miserable Distressing
Unable to do some activities because of pain

Intense, Dreadful Horrible
Unable to do most activities because of pain

Worse Pain Unbearable
Unable to do any activity becasue of pain

List Surgeries & Dates:

_____
_____
_____
_____
_____

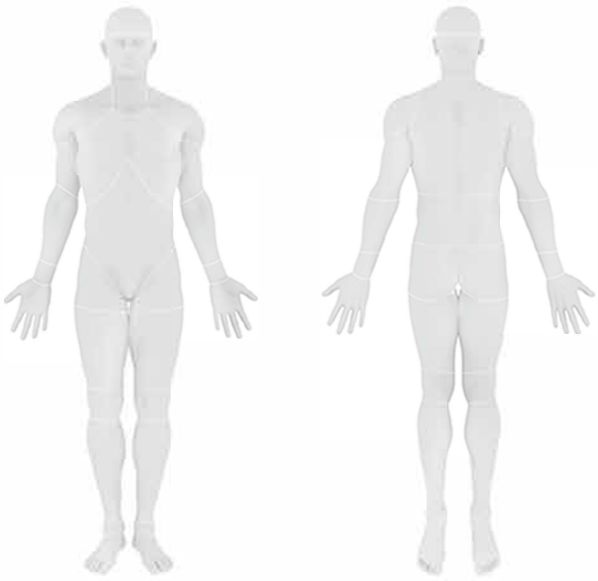
List Hospitalizations & Dates:

_____
_____
_____
_____
_____

List Current Medications & Supplements:

_____
_____
_____
_____
_____

PAIN DRAWING (To be completed in the clinic)



Please Print Legibly

CONSENT TO EVALUATE AND TREAT

I hereby request and consent to the performance of various modes of physical therapy on me (or the patient named below, for who I am legally responsible) by Pursuit Physical Therapy and/or other licensed physical therapists working at the clinic. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatments. I intend this consent form to cover the entire course of treatment of my present condition and for any future condition(s) for which I seek treatment. I understand that I may refuse treatment at any time and that I am responsible for my healthcare choices.

OUR PRIVACY POLICY

The office of Pursuit Physical Therapy is committed to upholding the security and confidentiality of personal information that you provide to us. We take responsibility of safeguarding your information very seriously. We do not share or sell patient information with anyone outside our office without your written consent. This policy covers information including personal, financial, or health information about a consumer or customer relationship.

I have been given a copy of the privacy policy of Pursuit Physical Therapy. I hereby authorize that my records of evaluation and treatment with the office of Pursuit Physical Therapy may be forwarded to referring physicians, specialists, or therapists, who are also involved in my healthcare. Your insurance claims will be transmitted through an electronic clearing house, in accordance with HIPPA regulations.

By agreeing below, I have read, or have had read to me, the above consent to evaluation and treatment statement, that I am aware of the privacy policy, and that I certify that my medical information above is correct to the best of my knowledge.

Patient's Initials *(parent/guardian if minor)*	Guardian Relationship
Full Name	Date