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PATIENT REGISTRATION FORM

Patient Name _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip _____

Mailing Address _____

Home Phone _____ (C) _____ (W) _____

Age _____ SS# _____ Marital Status: Married Single

Height _____ Ft _____ inches Weight _____ pounds

Your Employer Name & Phone _____

Your Occupation _____

Spouse _____ Spouse Date of Birth _____

Spouse's Employer Name & Phone _____

1) Name Of Emergency Contact 2) Phone Number 3) Patient Relationship

1) _____ 2) _____ 3) _____

Referring Physician _____ Next Doctors Appt _____

Primary care physician _____ Next Doctors Appt _____

If You Are A Minor:

Father's Name _____ Phone _____

Father's Employer _____

Mother's Name _____ Phone _____

Mother's Employer _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

Were you injured at work? **Yes No**

How did the pain start? Mark all that apply - Injury Suddenly Gradually Ongoing Problem
Unsure

Work Auto Accident Home Sports Lifting Twisting Bending Pulling Slip/Fall Other

(Please Explain) _____

When did this episode of pain start? Exact Date _____ Surgery Date _____

_____ Days Ago _____ Weeks Ago _____ Months Ago _____ Years Ago

DID YOU RECENTLY HAVE HOME HEALTH FOR THIS INJURY/ PROBLEM? YES / NO

IF YES, WE NEED YOUR DISCHARGE DATE _____

WE WILL NEED A COPY OF YOUR INSURANCE CARDS, DRIVER'S LICENSE OR PHOTO ID

***IF YOU HAVE HEALTHSMART BENEFIT SOLUTIONS INSURANCE (FORMERLY WELLS FARGO/PEIA)**

AQUATIC THERAPY IS NOT A COVERED BENEFIT AND THE INSURANCE WILL NOT PAY FOR THE POOL.*

Primary Insurance _____

Name of Insured _____ Date of Birth _____

Secondary Insurance _____

Name of the Insured _____ Date of Birth _____

Have you been evaluated or treated by another healthcare provider other than your referring physician for this condition? **Yes No**

In the past year, have you had any of the following? **Yes No** (Circle all that apply)

Physical / Occupational / Speech Therapy Acupuncture Chiropractic Care

If YES, how many visits and when were you seen?

P _____ O _____ S _____ A _____ CC _____

Pain is **Increased** by _____

Pain is **Decreased** by _____

What are you being seen for today? (Primary Complaint) _____

Have you fallen in the past 12 months? **Yes No** How many times? _____

Do you use tobacco? **Yes No** How much? _____

Do you use alcohol? (circle one) **Yes No**

Are you pregnant? **Yes No NA** Are you planning to be pregnant? **Yes No NA**

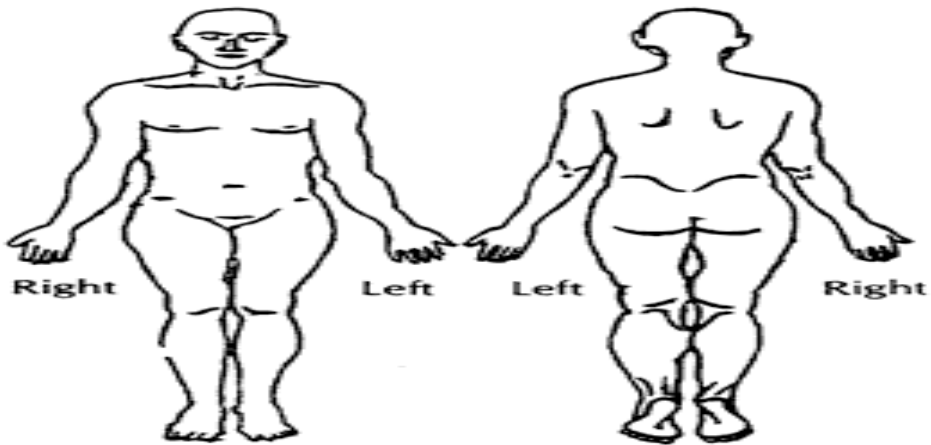
Are you allergic to any medications? **Yes No** What? _____

Prior Hospitalizations or Major Surgeries _____

Please circle any prior or recent testing relating to this condition? X-ray MRI CT Scan EMG Blood Work Bone Scan

What facility were these tests done? UHC Morgantown Other _____

Rate Your Pain	0 = Pain Free										10 = <u>Passing Out</u> from Pain
Right Now	0	1	2	3	4	5	6	7	8	9	10
Worst in past 24 hours	0	1	2	3	4	5	6	7	8	9	10
Best in past 24 hours	0	1	2	3	4	5	6	7	8	9	10



Please use the diagram and indicate where you feel your symptoms. Use the following key and write on the bodies the type of pain you feel.

Key: Pins & needles = 0000, Numbness = NNNN, Burning = XXXX
Deep Ache = ZZZZ, Stabbing pain = ////

PLEASE TURN OVER AND COMPLETE OTHER SIDE

Please mark the following if you have ever been diagnosed or treated for:

- | | |
|--|---|
| <input type="checkbox"/> Heart condition _____ | <input type="checkbox"/> Broken bones _____ |
| <input type="checkbox"/> Irregular heart beat _____ | <input type="checkbox"/> Back or Neck Injury _____ |
| <input type="checkbox"/> Circulatory problems _____ | <input type="checkbox"/> Muscle pain with activity _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Fibromyalgia _____ |
| <input type="checkbox"/> Shortness of breath _____ | <input type="checkbox"/> Unusual reaction to heat or cold _____ |
| <input type="checkbox"/> Chest pain or pressure _____ | <input type="checkbox"/> Night pain (while sleeping) _____ |
| <input type="checkbox"/> Calf pain _____ | <input type="checkbox"/> Hernias _____ |
| <input type="checkbox"/> Swollen ankles or legs _____ | <input type="checkbox"/> Pain with cough or sneeze _____ |
| <input type="checkbox"/> Fainting or dizziness _____ | <input type="checkbox"/> Stomach pain / ulcers _____ |
| <input type="checkbox"/> Stroke / CVA _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Blurred vision _____ | <input type="checkbox"/> Wound that does not heal _____ |
| <input type="checkbox"/> Recent weight loss / gain _____ | <input type="checkbox"/> Osteoporosis _____ |
| <input type="checkbox"/> Balance problems _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Frequent falls _____ | <input type="checkbox"/> Swollen or painful joints _____ |
| <input type="checkbox"/> Tremors _____ | <input type="checkbox"/> Jaw problems/ TMJ _____ |
| <input type="checkbox"/> Tingling / Numbness / Loss of feeling _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Difficulty swallowing _____ | <input type="checkbox"/> Liver Disease _____ |
| <input type="checkbox"/> Bowel / Bladder problems _____ | <input type="checkbox"/> Lung Disease _____ |
| <input type="checkbox"/> Weakness or Fatigue _____ | <input type="checkbox"/> Unusual skin coloration _____ |
| <input type="checkbox"/> Epilepsy /Seizures / Convulsions _____ | <input type="checkbox"/> Latex Allergy _____ |
| <input type="checkbox"/> Recent Accident _____ | <input type="checkbox"/> Cancer / Tumors _____ |
| <input type="checkbox"/> Headaches _____ | <input type="checkbox"/> Nervous or emotional problems _____ |
| <input type="checkbox"/> Whiplash _____ | <input type="checkbox"/> Difficulty sleeping _____ |
| <input type="checkbox"/> Head Trauma / Concussion _____ | <input type="checkbox"/> Infectious Disease (HIV / Hepatitis) _____ |
| <input type="checkbox"/> Joint dislocations _____ | <input type="checkbox"/> Allergies (Medication) _____ |
| <input type="checkbox"/> Pacemaker _____ | <input type="checkbox"/> Joint Replacement _____ |

IF YOU DO NOT HAVE A COPY OF YOUR MEDICATIONS, PLEASE LIST THEM:

(Please read the attached Notice of Information Practices and the Consent for treatment information before signing this page.)

I understand and agree that I am ultimately responsible for payment of my account for any professional services rendered. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to Affiliated Physical Therapy, LLC. By signing below I indicate that I have read and agree with the Notice of Information Practices and the Consent for Treatment Information.

Signature: _____ Date: _____

Parent's signature, if patient is a minor:

_____ Date: _____