CLIENT REGISTRATION FORM

NAME:_____
LAST FIRST MIDDLE

DATE OF BIRTH: ___/___/___ SEX: ☐ M / ☐F SOCIAL SECURITY#: _____-_____-_____

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: _____ MOBILE: _____ WORK: _____

EMAIL ADDRESS:_____

EMPLOYER: _____
NAME STREET CITY STATE ZIP

EMERGENCY CONTACT:_____ **PHONE:** _____

PRIMARY CARE PHYSICIAN:_____ **REFERRING PHYSICIAN:**_____

DATE OF NEXT PHYSICIAN FOLLOW UP FOR THIS INJURY:_____

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS BY: ☐ **EMAIL** ☐ **PHONE** ☐ **TEXT**

WOULD YOU LIKE TO RECEIVE YOUR EXERCISE PRESCRIPTION AND/OR HEALTH INFORMATION RELATED TO YOUR CARE VIA EMAIL: ☐**Y** / ☐**N**

HOW DID YOU HEAR ABOUT WHIDBEY PERFORMANCE PT? ☐ **FRIEND** ☐ **DOCTOR** ☐ **WEBSITE** ☐ **OTHER**

PRIMARY HEALTH INSURANCE:
HEALTH INSURANCE CARRIE:_____
POLICY/ID#:_____ SUBSCRIBER:_____
RELATION:_____ SUBSCRIBER SOCIAL SECURITY#:_____-_____-_____

SECONDARY HEALTH INSURANCE (IF APPLICABLE):
HEALTH INSURANCE CARRIE:_____
POLICY/ID#:_____ SUBSCRIBER:_____
RELATION:_____ SUBSCRIBER SOCIAL SECURITY#:_____-_____-_____

AUTO INSURANCE:
(LIST **YOUR** AUTO INSURANCE CARRIER, REGARDLESS OF FAULT, IF INJURY IS DUE TO MVA)
INSURANCE CARRIER NAME:_____ CLAIM #: _____
ADJUSTER'S NAME:_____ PHONE:_____ INJURY DATE:_____

WORKER'S COMPENSATION:
INSURANCE CARRIER NAME:_____ CLAIM #: _____
ADJUSTER'S NAME:_____ PHONE:_____ INJURY DATE:_____

ATTORNEY INFORMATION (IF REPRESENTING YOU FOR INJURY YOU ARE SEEKING TREATMENT FOR):
NAME:_____
PHONE:_____ FAX:_____

I VERIFY THE ABOVE INFORMATION IS ACCURATE:

_____ _____/_____/_____
CLIENT OR GUARDIAN SIGNATURE **MONTH DAY YEAR**

HEALTH HISTORY FORM

WHIDBEY PERFORMANCE PHYSICAL THERAPY

Name _____ **Date** _____

History Of Current Condition

Current Symptoms:_____

_____

_____

When did symptoms begin?_____

Was surgery performed? ☐ Y / ☐ N

Was symptoms onset ☐ **gradual or** ☐ **sudden?**

Which best describes how injury occurred?

- ☐ Lifting
- ☐ Overuse
- ☐ Trauma
- ☐ Running
- ☐ Unknown
- ☐ Fall
- ☐ Car Accident
- ☐ Sport
- ☐ Incident at Work
- ☐ Other:_____

Since onset are symptoms getting:

☐ Better ☐ Worse ☐ No change

Have you had similar symptoms in the past?

☐ Y / ☐ N

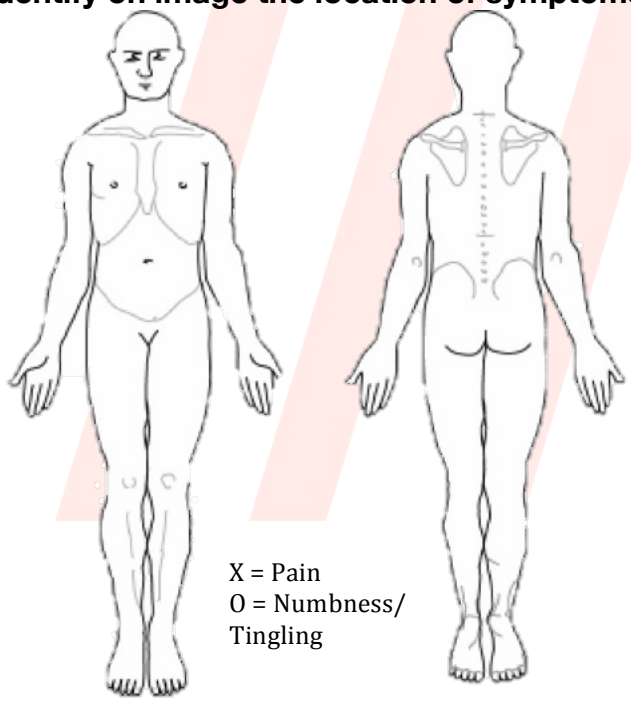
Description of symptoms:

- ☐ Sharp
- ☐ Throbbing
- ☐ Constant
- ☐ Occasional
- ☐ Dull
- ☐ Aching
- ☐ Periodic
- ☐ Other:_____

If pain is present, what level is it (0 = No pain, 10 = Worst imaginable pain):

_____Currently _____Best _____Worst

Identify on image the location of symptoms:



Does pain wake you at night? ☐ Y / ☐ N

Do you have symptoms when getting out of bed in morning? ☐ Y / ☐ N

What position do you sleep?

- ☐ Right side
- ☐ Stomach
- ☐ Recliner
- ☐ Left side
- ☐ Back
- ☐ Multiple Positions

Have you recently had any of the following:

- ☐ Changes in bowel or bladder function
- ☐ Numbness/tingling
- ☐ Fainting
- ☐ Headaches
- ☐ Weight change
- ☐ Vision changes
- ☐ Fever/Chills
- ☐ Dizziness
- ☐ Falls / Difficulty balancing
- ☐ Weakness
- ☐ Night sweats
- ☐ Night pain

What causes your symptoms to worsen?

- ☐ Sitting
- ☐ Squatting
- ☐ Lying down
- ☐ Standing up from a seated position
- ☐ Reaching overhead
- ☐ Reaching across body
- ☐ Sports/recreation
- ☐ Coughing
- ☐ Bending
- ☐ Standing
- ☐ Sleeping
- ☐ Walking
- ☐ Stairs: ☐ Up ☐ Down
- ☐ Reaching behind back
- ☐ Eating
- ☐ Household activities
- ☐ Taking a breath
- ☐ Other:_____

What decreases your symptoms?

- ☐ Sitting
- ☐ Walking
- ☐ Cold
- ☐ Splint
- ☐ Exercise
- ☐ Massage
- ☐ Standing
- ☐ Heat
- ☐ Stretching
- ☐ Medication
- ☐ Lying down
- ☐ Nothing
- ☐ Other: _____

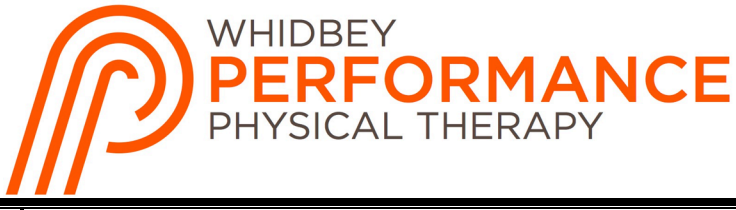
Have you been treated for this condition previously?

- ☐ None
- ☐ Exercises
- ☐ Bracing
- ☐ Muscle injections
- ☐ Joint manipulation
- ☐ Hospitalization
- ☐ Medication
- ☐ Massage therapy
- ☐ Spine injections
- ☐ Physical therapy
- ☐ Acupuncture
- ☐ Other:_____

Have you had any of the following tests?

- ☐ None
- ☐ MRI
- ☐ X-Ray
- ☐ Fluoroscope
- ☐ Arthrogram
- ☐ Vestibular test
- ☐ CT Scan
- ☐ Bone Scan
- Other:_____

HEALTH HISTORY FORM



Name _____ **Date** _____

Please list any medications you are taking:

Medication	Dose	Reason for use

(If all medication do not fit here provide list on additional page)

Prior Level Of Function

- ☐ Independent
- ☐ Requires assistance with self-care tasks
- ☐ Requires assistance with household tasks
- ☐ Requires assistance with activities in the community
- ☐ Requires use of assistive device
- Type of assistive device:_____

Work History:

Occupation:_____

☐ Fulltime ☐ Part-time ☐ Unemployed
☐ Disability ☐ Retired

Work Requirements:

☐ Sitting ☐ Computer use ☐ Repetitive lifting
☐ Lift >30 lbs ☐ Driving ☐ Standing

Current Level Of Function:

- ☐ Independent
- ☐ Requires assistance with self-care tasks
- ☐ Requires assistance with household tasks
- ☐ Requires assistance with activities in the community
- ☐ Requires use of assistive device
- Type of assistive device:_____

Living Environment:

- ☐ Live alone
- ☐ Live with family members
- ☐ Live with caregiver
- ☐ Assisted living facility
- ☐ Skilled nursing facility
- ☐ Other:_____

Are there stairs present?: ☐ Y / ☐ N
Do stairs have railings: ☐ Y / ☐ N
Number of falls in past year: ☐1x ☐2x ☐≥3x

Medical History:

General Health:

☐ Excellent ☐ Good ☐ Average
☐ Fair ☐ Poor

Height:_____**Weight:**_____

Do you smoke: ☐ Y / ☐ N

Stress Level: ☐ Low ☐ Medium ☐ High

Allergies (list):

_____
_____
_____
_____
_____

Past Medical History;

- ☐ Cancer (type)_____
- ☐ Depression
- ☐ Stroke
- ☐ Hypothyroidism
- ☐ Diabetes
- ☐ Hyperthyroidism
- ☐ Arthritis
- ☐ Head injury
- ☐ Parkinson's disease
- ☐ Infectious diseases
- ☐ Tuberculosis
- ☐ Multiple sclerosis
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Lung problems
- ☐ Blood disorder
- ☐ Epilepsy/seizures
- ☐ Fibromyalgia
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Other: _____

Past Surgical History:

Surgery	Date

Family Medical History:

Has anyone in your immediate family been diagnosed with any of the following?:

- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Other:_____

Your Physical Therapy Goals:

_____
_____
_____