PERRY PHYSICAL THERAPY, INC.

2306 W. Lansing Rd • Morrice, MI 48857

PATIENT REGISTRATION

Name ______________________________ Date ______________
Last First MI

Address ____
Street City State Zip Code

Phone *(w/area code)* ____________ Work Phone ____________ Cell Phone ____________

Social Security Number ____________ Birth Date ____________ E-mail Address ____________

Sex: ☐ Female ☐ Male

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ American Indian ☐ Asian ☐ Black ☐ Caucasian ☐ Other ____________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Declined

Language: ☐ English ☐ Spanish ☐ Other ____________

Employer ____________ Occupation ____________

Employer's Address ____________ Your Primary Care Physician ____________

Referring Physician ____________ Date of your next visit ____________

Name of person who should receive statement *(other than patient)* ____________

Statement address *(if different than patient's address)* ____________

Who should we contact in an emergency? ____________ Phone Number ____________

INSURANCE INFORMATION *(PLEASE GIVE YOUR CARDS TO RECEPTIONIST FOR COPYING)*

Primary Insurance ____________

Insured's Name ____________ Birth Date ____________

ID Number ____________ Group Number ____________

Secondary Insurance ____________

Insured's Name ____________ Birth Date ____________

ID Number ____________ Group Number ____________

IF YOU HAD AN ACCIDENT *(PLEASE COMPLETE THIS SECTION)*

Date of accident How did it happen? ☐ Auto ☐ Work ☐ Other (location) ____________

Involvement in Accident if Auto ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Cyclist

Attorney's *(Name/Address/Phone)* ____________

Insurance Company *(worker's comp or your auto PIP)* ____________

Address ____________ Phone Number ____________

Claim Number ____________ Adjuster ____________ Name of Insured ____________

Please tell us how you learned of our service or whom we can thank.

☐ I was a Former Patient
☐ Doctor recommendation
☐ Insurance Company recommendation
☐ Health Club recommendation
☐ Clinic Sign
☐ TV advertisement
☐ Former Patient recommendation
☐ Family or Friend recommendation
☐ Employer recommendation
☐ Newspaper advertisement
☐ Billboard advertisement
☐ Radio advertisement
☐ Case Manager recommendation
☐ Yellow Page advertisement
☐ Web page

Name ____________

Name ____________

I learned about you another way. *(please explain)* ____________

PATIENT SIGNATURE ____________ Date ____________

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PATIENT QUESTIONNAIRE / HEALTH HISTORY

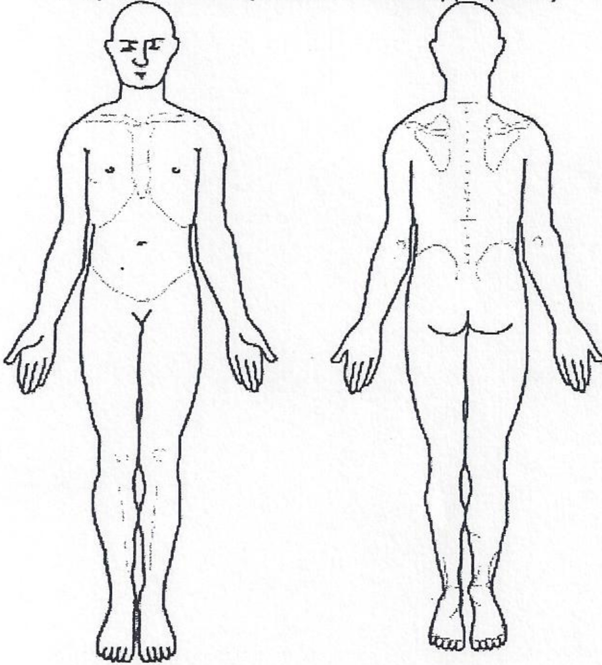
NAME: ______________________ **DATE:** ____________

To insure you receive a complete and thorough evaluation. please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

1. What are your symptoms? ______________________________

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)



2. When did your symptoms begin?
(Please indicate a specific date if possible)____________

3. Was the **onset** of this episode gradual or sudden?(Check one)
☐ (1) gradual ☐ (2) sudden

4. Which of the following **best describes** how your injury occurred? (if your condition is post-surgical please indicate as per original injury)
☐ (1) lifting
☐ (2) a MVA (car accident
☐ (3) a fall
☐ (4) overuse (cumulative trauma)
☐ (5) trauma
☐ (6) degenerative process
☐ (7) during recreation/sports
☐ (8) running
☐ (9) a blow to the face
☐ (10) being hit by a ball
☐ (11) a dental appointment
☐ (12) throwing
☐ (13) an incident at work
☐ (14) unknown
☐ (15) other ____________

5. Since onset, are your symptoms getting: (Check one)
☐ (1) better ☐ (2) worse ☐ (3) not changing

6. Have you had similar symptoms in the past? (1)☐ Yes (2) ☐ No
More than one episode? (1) ☐ Yes (2) ☐ No

7. Nature of pain/symptoms (check all that apply)
☐ (1) sharp
☐ (2) dull
☐ (3) throbbing
☐ (4) aching
☐ (5) periodic
☐ (6) occasional
☐ (7) constant
☐ (8) other ______

8. As the day progresses, do your symptoms: (Check one)
☐ (1) increase ☐ (2) decrease ☐ (3) stay the same

9. Does the pain wake you at night? ☐ (1) No ☐ (2) Yes
if "*yes*", is it present ☐ (1) while lying still
☐ (2) only when changing positions
☐ (3) both

10. Do you have pain/stiffness upon getting out of bed in the morning? ☐ (1) Yes ☐ (2) No

11. In what position do you sleep? (Check all that apply)
☐ (1) right side
☐ (2) left side
☐ (3) stomach
☐ (4) back
☐ (5) chair/recliner
☐ (6) back, sides, stomach
☐ (7) other ____________

12. Since the onset of your current symptoms have you had:
☐ (1) any difficulty with control of bowel or bladder function
☐ (2) fever/Chills
☐ (3) any numbness in the genital or anal area
☐ (4) numbness
☐ (5) any dizziness or fainting attacks
☐ (6) weakness
☐ (7) unexplained weight change
☐ (8) night pain/sweats
☐ (9) malaise (vague feeling of bodily discomfort)
☐ (10) problems with vision/hearing
☐ (11) none of the above

13. What aggravates your symptoms? (Check all that apply)
☐ (1) sitting
☐ (2) going to/rising from sitting
☐ (3) lying down
☐ (4) walking
☐ (5) up/down stairs
☐ (6) reaching overhead
☐ (6) reaching in front of body
☐ (6) reaching behind back
☐ (6) reaching across body
☐ (7) talking, chewing, yawning, all (*circle one*)
☐ (8) recreation/sports including ____________
☐ (9) repetitive activities including ____________
☐ (10) household activities including ____________
☐ (11) standing
☐ (12) squatting
☐ (13) sleeping
☐ (14) coughing/sneezing
☐ (15) taking a deep breath
☐ (16) looking up overhead
☐ (17) swallowing
☐ (18) stress
☐ (19) sustained bending
☐ (20) other ____________

14. What relieves your symptoms? (Check all that apply)
☐ (1) sitting
☐ (2) heat
☐ (3) cold
☐ (4) stretching
☐ (5) wearing a splint/orthosis
☐ (6) rest
☐ (7) standing
☐ (8) walking
☐ (9) exercise
☐ (10) lying down
☐ (11) massage
☐ (12) medication
☐ (13) nothing
☐ (14) other______

15. Have you had any previous treatment for this condition? (Check all that apply)

- ☐ (1) none
- ☐ (2) medication (oral)
- ☐ (3) joint manipulation
- ☐ (4) exercise
- ☐ (5) massage therapy
- ☐ (6) traction
- ☐ (7) bracing/taping
- ☐ (8) injection into the spine
- ☐ (9) injection into the skin/muscles
- ☐ (10) physical therapy
- ☐ (11) hypnosis
- ☐ (12) biofeedback
- ☐ (13) TENS unit
- ☐ (14) acupuncture
- ☐ (15) bed rest
- ☐ (16) overnight hospitalization
- ☐ (17) casting
- ☐ (18) other__________

16. Have you had any of the following tests?

- ☐ (1) none
- ☐ (2) x-rays
- ☐ (3) CT Scan
- ☐ (4) MRI
- ☐ (5) Arthrogram
- ☐ (6) Stress X-ray Test (Telos)
- ☐ (7) Bone Scan
- ☐ (8) NCS
- ☐ (9) Fluoroscope
- ☐ (10) Vestibular
- ☐ (11) other__________

Test Results:____________________

MEDICATION

Please list any prescription medications you are currently taking (*pain pills, injections and/or skin patches, etc.*):

____

Prescribing MD:________________ Phone:__________

Are you currently taking any of the following over the counter medications?

- ☐ (1) aspirin
- ☐ (2) Tylenol
- ☐ (3) corticosteroids
- ☐ (4) antihistamines
- ☐ (5) vitamins/mineral supplements
- ☐ (6) Advil/Motrin/ Ibuprofen
- ☐ (7) other__________

PREVIOUS FUNCTIONAL LEVEL

☐ **Independent in all activities** (work, community, home, recreation)

Self-care

- ☐ Independent in all self-care activities (bathing, toileting, dressing, etc.)
- ☐ Difficulty performing self-care activities
- ☐ Need assistance with self-care activities
- ☐ Difficulty performing household chores

Social

- ☐ Need assistance with activities in community outside of home

Hobbies:____________________

WORK HISTORY

Occupation____________________

- ☐ (1) employed full time
- ☐ (2) employed part time
- ☐ (3) self employed
- ☐ (4) homemaker
- ☐ (5) student
- ☐ (6) retired
- ☐ (7) unemployed
- ☐ (8) other__________

Physical activities at work (check all that apply)

- ☐ (1) sitting
- ☐ (2) standing
- ☐ (3) phone use
- ☐ (4) repetitive lifting
- ☐ (5) heavy lifting
- ☐ (6) computer use
- ☐ (7) heavy equipment operation
- ☐ (8) driving
- ☐ (9) other__________

Are you currently receiving or seeking disability for this condition? ☐ (1) Yes ☐ (2) No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

☐ (1) Yes ☐ (2) No

LIVING SITUATION

- ☐ (1) live alone
- ☐ (2) live with family members/others
- ☐ (3) live with caregiver
- ☐ (4) home/apartment
- ☐ (5) retirement complex (SNF/ICF)
- ☐ (6) assisted living complex
- ☐ (7) other__________

Setting

- ☐ (1) stairs (railing)
- ☐ (2) stairs (no railing)
- ☐ (3) no stairs
- ☐ (4) ramp
- ☐ (5) elevator
- ☐ (6) uneven ground
- ☐ (7) other__________

GENERAL HEALTH

How would you rate your general health?

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Do you exercise outside of normal daily activities?

☐ 5+ days/wk ☐ 3-4 days/wk ☐ 1-2 days/wk ☐ occasionally ☐ zero

Exercise, Sports/Recreation consisting of ____________________

Do you drink caffeinated beverages?

☐ No ☐ Yes How many/much per day__________

Do you smoke?

☐ No ☐ Yes Packs of cigarettes per day__________

What is your stress level?

☐ Low ☐ Medium ☐ High

Are you seeing any health care providers other than the physical therapist for this current condition? (Please list)__________

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

- ☐ Cancer (type)__________
- ☐ Depression
- ☐ Stroke
- ☐ Kidney problems
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Multiple sclerosis
- ☐ Arthritis
- ☐ Head injury
- ☐ Stomach problems
- ☐ Parkinson's disease
- ☐ Infectious diseases (i.e. hepatitis, tuberculosis, etc.)
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Lung problems
- ☐ Blood disorders
- ☐ Epilepsy/seizures
- ☐ Allergies
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Broken bone
- ☐ Circulation/vascular problems
- ☐ Other__________

Please list any recent/relevant past surgeries related to your current problem:

SURGERY	DATE

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated of any of the following?

- ☐ Diabetes
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Stroke
- ☐ Other__________
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Psychological condition

Patient Signature____________________