Appalachian Physical Therapy, Inc.

"There's a difference you can feel"

MINOR REGISTRATION FORM

Patient's Name____ ☐ **Male** ☐ **Female**______
(First) (Middle Initial) (Last)

Street Address________________________________ **Apt** ___**Mailing**__________________________

City__________________________________**State**______________________**Zip**____________

Phone_______________ **Social Security**________________ **Date of Birth**____/____/______ **Age**______

Email ______________________________________ ☐ **Check here if you wish to receive our newsletter**

May we leave a message on your: Phone_______ **Cell Phone**_______ **Text Message**_______ **E-mail**_________

Cell Phone Provider ____________________________ **(needed for sending appointment reminders)**

Father's Name ______________________ **Date of Birth** ____/____/____ **Social Security** ________________

Father's Employer ____ **Phone** ____________________

Address ____

Mother's Name ______________________ **Date of Birth** ____/____/____ **Social Security** ______________

Mother's Employer ____ **Phone** ____________________

Address ____

Date of injury, if known_______________ **Referring Physician** __________________________________

Person who recommended our services if other than physician__________________________________

Have you been a patient here before? _____ **Have you had physical therapy or chiropractic in the past 12 months**______

Person to Contact in Case of Emergency__________________________________ **Phone** ______________

Nearest relative not living with you _____________________________________ **Phone** ______________

Address ____

I desire that physical therapy services be provided to me and understand it will be my responsibility to pay for these services if my insurance does not pay or if my insurance benefits are paid to me inadvertently. I request that payment of authorized insurance benefits for services be preassigned to Appalachian Physical Therapy.

I understand that any balance remaining on my account after 60 days from the date of service is subject to interest charges at the rate of 2% per month. I understand I am responsible for all registered mail fees, court costs, and attorney fees incurred as a result of collection efforts on this account.

Patient Representative/
Legal Guardian Signature ____ **Date**____________

PRIVACY PRACTICES

Please review APT's Notice of Privacy Practices provided and initial your desired option below.

☐ *I am aware of APT's Privacy Practices, but decline a personal copy.*

☐ *I am aware of APT's Privacy Practices and request a personal copy.*

PATIENT MEDICAL HISTORY

Name: ____

One of the factors that enables us to provide "a different kind of physical therapy" is our comprehensive, total body approach. We recognize from evidence and experience that the body works as a unit: problems in one area/system can influence another. This is why we ask questions about many body parts and system functions that may seem to have nothing to do with what brings you here. Knowing about past, present, and recurrent issues you have experienced can better direct our treatment of you and lead to a more successful outcome – with your primary complaint as well as issues you may have assumed you had to endure. Thank you for the trust you demonstrate in seeking healthcare from us.

If you do not understand a question, please ask and we will be happy to assist you.

- Are you latex sensitive? Yes No
- Are you allergic to heat or cold on your skin? Yes No Unsure
- Are you pregnant or think you might be pregnant? Yes No
- Do you have anything implanted in your body that you were not born with? (Electrical stimulator, metal rods/screws, mesh, cosmetic implants, pacemaker, oral appliance, intra-uterine device, etc.)
  - Yes No
  - If yes, please explain what type and where located: ______________________________________
- Do you typically use or wear any type of extrinsic device? (Heel lift, sacral belt, shoe orthotics, removable oral appliance or night guard, etc.)
  - Yes No
  - If yes, please explain: ____

Please indicate if you are currently under the care of any of the following health care providers:

- ☐ PCP (Primary Care Provider: Medical doctor, osteopath, nurse practitioner, physician assistant)
- ☐ Dentist
- ☐ Oral surgeon
- ☐ Orthodontist
- ☐ Psychiatrist/Psychologist
- ☐ Physical Therapist (outside of this organization)
- ☐ Chiropractor
- ☐ Massage therapist
- ☐ Other (please specify): __________ ______________________________ ______________________________ ______________________________

If you have seen any of the above within the last three months, please describe for what reason (illness, medical condition, physical, etc.): ____
____

MEDICAL/SURGICAL HISTORY

- Please indicate if you experience problems with or have been diagnosed with any of the following conditions:
  - ☐ Arthritis
  - ☐ Broken bones/fractures
  - ☐ Osteoporosis
  - ☐ Blood disorders
  - ☐ Circulation/vascular problems
  - ☐ Heart problems
  - ☐ Hypertension (high blood pressure)
  - ☐ Cholesterol
  - ☐ Lung problems
  - ☐ Stroke
  - ☐ Diabetes
  - ☐ Hypoglycemia
  - ☐ Thyroid problems
  - ☐ Kidney problems
  - ☐ Head injury
  - ☐ Developmental or growth problems
  - ☐ Multiple sclerosis
  - ☐ Degenerative Disc Disease
  - ☐ Degenerative Joint Disease
  - ☐ Disc Herniation
  - ☐ RLS (Restless Leg Syndrome)
  - ☐ Endometriosis
  - ☐ Organ prolapse
  - ☐ Hernia
    Was it repaired? Yes No
  - ☐ Complications during birth (e.g. premature, low/high birth weight, complications with delivery, etc.)
  - ☐ Muscular dystrophy
  - ☐ Parkinson's disease
  - ☐ Seizures/epilepsy
  - ☐ Skin disease
  - ☐ Cancer
  - ☐ Repeated infections
  - ☐ Depression
  - ☐ Infectious disease
  - ☐ Ulcers/stomach problems
  - ☐ Chemical dependency
  - ☐ Alcohol abuse
  - ☐ Prostatitis
  - ☐ Other: _________________ ________________________ ________________________

- Are you currently experiencing or do you have a history of any of the following symptoms?
  - ☐ Chest pain
  - ☐ Heart palpitations
  - ☐ Cough
  - ☐ Hoarseness
  - ☐ Shortness of breath
  - ☐ Dizziness or blackouts
  - ☐ Coordination problems
  - ☐ Weakness in arms/legs
  - ☐ Numbness/tingling
  - ☐ Cramping or other symptoms (legs, feet, arms, hands, other)
  - ☐ Loss of balance
  - ☐ Difficulty walking
  - ☐ Joint pain or swelling
  - ☐ Difficulty sleeping
  - ☐ Loss of appetite
  - ☐ Nausea/vomiting
  - ☐ Difficulty swallowing
  - ☐ Bowel problems (constipation, diarrhea)
  - ☐ Acid reflux
  - ☐ Heartburn
  - ☐ Weight loss/gain
  - ☐ Urinary problems (e.g. incontinence/involuntary loss of urine, frequency, urgency, pain, difficulty initiating, need to use bathroom more than once nightly)
  - ☐ Fever/chills/sweats
  - ☐ Headaches
  - ☐ Hearing problems
  - ☐ Vision problems
  - ☐ Fatigue
  - ☐ Sinus problems
  - ☐ Other ____

- If applicable, please answer the following questions regarding pregnancy and childbirth.
  - How many pregnancies have you had? _____
  - How many vaginal deliveries? _______ C-sections? _______ Episiotomies? _______
  - Have you had any complications with or since any childbirth? Yes No
    - If yes, please explain: ____
      ____

- Please indicate if you have ever had imaging performed, the approximate date(s), and to what body part(s).
  - ☐ MRI ______________________________________
  - ☐ X-Rays ____________________________________
  - ☐ CT Scan ___________________________________
  - ☐ Other______________________________________

  Where were the test(s) performed? RMH UVA Doctor's Office Other________________

- Please list any surgeries or hospitalizations, including the approximate date and reason:
  ____
  ____
  ____

- Please describe any significant injuries for which you have been treated and the approximate date of injury:
  ____
  ____
  ____
  ____

- Have you ever been involved in a motor vehicle accident with injury (even minor)? ☐ Yes ☐ No
  If yes, please list the approximate date(s): ____

FAMILY HISTORY

- Please indicate whether anyone in your immediate family (parents, siblings, grandparents) have been diagnosed with the following and list the age of onset if known:
  - ☐ Heart disease __________________
  - ☐ Hypertension __________________
  - ☐ Stroke ______________________
  - ☐ Diabetes _____________________
  - ☐ Cancer ________________________
  - ☐ Psychological __________________
  - ☐ Arthritis ______________________
  - ☐ Osteoporosis _________________
  - ☐ Other: _________________________

MEDICATIONS

- Please list here any prescription medications you are currently taking (or provide us with a separate list): _________
  ____
  ____
  ____

- Are you taking any of the following nonprescription medications?

☐ Aspirin	☐ Decongestants
☐ Advil/Aleve/Motrin/Ibuprofen	☐ Laxatives
☐ Tylenol	☐ Antacid
☐ Antihistamines	☐ Vitamins
☐ Herbal supplements	☐ Other: _________________________

SOCIAL/HEALTH HABITS

- Do you currently use tobacco products? ☐ Yes ☐ No
  - If yes, how many packs per day do you smoke? _______
- Have you used tobacco products in the past? ☐ Yes ☐ No
  - If yes, in what year did you quit? _______
- How many caffeinated beverages do you drink per day? _______
- Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No
  - If yes, please describe the type of exercise, how many times per week, and for how long each day.
    ____

Patient Signature: ____ Date: ________________

Therapist Signature: ____ Date: ________________