ASCENT
Physical Therapy
Specialists Inc.

PATIENT REGISTRATION

Contact Information:

Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Mobile Phone: _____ Home Phone: _____

Email Address: _____

Emergency Contact: Name: _____ Relation: _____

Address: _____

Phone: _____

Employer: (If you are under 18 please list your parents' employers here)

Company Name: _____

Address: _____ City: _____

Zip: _____ Work Phone: _____ Work Fax: _____

Referring Physician: Name: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Fax: _____

Workers Comp or Auto Injury ONLY:

Date of Injury: _____ State injury occurred in: _____ Carrier: _____

Carrier Address: _____ City: _____

State: ____ Zip: _____ Case Worker: _____

Case Worker Phone: _____ Fax Number: _____

Claim Number: _____

How did you hear about Ascent Physical Therapy Specialists Inc? (Circle best answer):

Doctor	Managed Care plan or list	Employer
Friend or Relative	Internet Search	Other: _____

Name: _____

Date: _____

Where did you hear about us? _____

ASCENT Physical Therapy Specialists Inc.

Please check the following conditions as they apply to you:		
o Allergies	o Depression	o Multiple Sclerosis
o Anemia	o Diabetes	o Osteoporosis
o Anxiety	o Dizzy Spells	o Parkinsons
o Arthritis	o Emphysema/Bronchitis	o Rheumatoid Arthritis
o Asthma	o Fractures	o Seizures
o Cancer	o Gallbladder Problems	o Speech Problems
o Cardiac Conditions	o Hepatitis	o Strokes
o Cardiac Pacemaker	o High Blood Pressure	o Thyroid Disease
o Chemical Dependency	o Incontinence	o Tuberculosis
o Circulation Problems	o Kidney Problems	o Vision Problems
o Currently Pregnant	o Metal Implants	

1. Are you currently taking any medications? **Y / N**

Medication	Dosage	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Have you had any past surgical procedures? **Y / N**

If yes, please list and include date of surgery: _____

3. Previous serious illness or injury? _____

4. Are you currently pregnant? **Y / N** **5. Have you been pregnant in the last year?** **Y / N**

6. Do you smoke? **Y / N** **7. Do you drink alcohol?** **Y / N**

8. Have you received physical therapy previously? **Y / N** **9. Have you received PT for this injury?** **Y / N**

10. Known Allergies? _____ **11. Are you currently receiving home health care?** **Y / N**

12. Is this work related? **Y / N** **13. Is this related to an auto accident?** **Y / N**

14. Please describe your injury and location of pain: _____

_____

_____

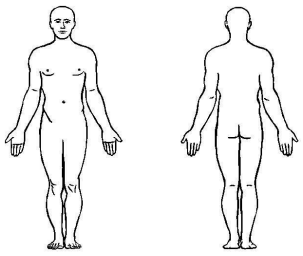
15. Date of injury/onset of pain: _____

Please circle your level of pain:

0 1 2 3 4 5 6 7 8 9 10

Please circle any that apply to your level of pain:

Sharp Burning Aching



Circle area of injury

Signature: _____ **Date:** _____