L A R Physical Therapy Registration & Medical History

Date: _____/_____/_____ How did you hear of **L A R Physical Therapy**? _____

Reason for visit: ☐ Physical Therapy ☐ Fitness ☐ Dance enhancement ☐ Post-Rehab

Patient Name: Last: _____ First: _____ MI: _____

Address: _____

_____

Date of Birth: _____/_____/_____ **Age**: _____ **Gender**: ☐ M / ☐ F **Marital Status**: _____

Best Phone Number: _____ May we text: ☐ Y / ☐ N **Alternate #:** _____

Email: _____

Occupation / Employer: _____

Emergency Contact Name: _____ **Phone**: _____

Physician Name:_____ **Phone**: _____

(THOSE FILING WITH INSURANCE FILL OUT BELOW) Please bring insurance card to copy

Insured Name: Last:_____ First: _____ MI: _____

Address: _____

_____ **Email:** _____

Date of Birth: _____/_____/_____ **Age**: _____ **Gender**: ☐ M / ☐ F **Marital Status**: _____

Insured's Home Phone: _____ **Out of Network Benefits**: ☐ Yes ☐ No ☐ Unsure

Insurance Company: _____ **ID/Subscriber/Policy Number**: _____

MEDICAL HISTORY

General Health (check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Last Physical with Primary Care: _____/_____/_____ Regular Vision & Hearing checks? ☐ Yes ☐ No

Do you have concerns about your diet? ☐ Yes ☐ No Are you hydrating adequately? ☐ Yes ☐ No

Caffeine ☐ Yes ☐ No # drinks/day _____ Average hours of sleep per night: _____

Alcohol: ☐ Yes ☐ No If yes, please specify: amount/day, week, or month: _____

Tobacco ☐ Yes ☐ No If yes, please specify ppd: _____ years: _____

Prescriptions Medications: _____

Over-the-counter Medications: _____

Present/past medical conditions: Please check all conditions that apply and give further description below

☐ Allergies: _____
☐ Arthritis
☐ Asthma or other lung disease
☐ Blood disorder
☐ Bone fractures
☐ Cancer
☐ Circulation, vascular problems (i.e. burning cramping sensation in lower legs when walking short distances)
☐ Depression
☐ Diabetes or high blood sugar
☐ Head injury / Concussion
☐ Heart problems
☐ High cholesterol
☐ Hypertension
☐ Thyroid problems
☐ Hypoglycemia or low blood sugar
☐ Infectious disease (e.g., tuberculosis, hepatitis, HIV)
☐ Kidney problems
☐ Lung problems (including chronic obstructive pulmonary disease)
☐ Multiple sclerosis
☐ Muscular dystrophy
☐ Musculoskeletal problems
☐ Osteoporosis
☐ Parkinson disease
☐ Repeated infections
☐ Seizures, epilepsy
☐ Skin diseases or open wounds
☐ Stroke
☐ Ulcers, stomach problems

Men: ☐ History of prostate disease

Women:
☐ History of endometriosis
☐ Pelvic disorders
☐ Pregnancies and pregnancy-related pain
☐ Vaginal or ☐ caesarian deliveries
☐ Regular menstrual cycle ☐ Irregular

Within the past year:

☐ Bowel problems
☐ Chest pain or chest discomfort with exertion
☐ Chronic cough
☐ Coordination problems
☐ Dizziness, fainting, or blackouts
☐ Difficulty sleeping
☐ Difficulty swallowing
☐ Fatigue
☐ Fever, chills, or sweats
☐ Heart palpitations
☐ Headaches
☐ Hernias
☐ Loss of appetite
☐ Loss of balance
☐ Nausea/vomiting
☐ Pain that wakes you in the night
☐ Pain with sexual activity
☐ Pelvic or abdominal bloating or pain
☐ Restrictions from scars
☐ Shortness of breath
☐ Urinary problems ☐ Incontinence
☐ Weakness or swelling in arms or legs
☐ Weight loss or gain

Description of conditions (if needed): _____

_____

_____

Have you had any **medical problems** or hospitalization in the past year? ☐ Yes ☐ No

If "yes", please specify: _____

_____

_____

Surgical History:

Procedure: _____ Date: _____/_____/_____
Procedure: _____ Date: _____/_____/_____
Procedure: _____ Date: _____/_____/_____

Family history:

Please give relationship and age of onset if known.

☐ Heart disease _____ ☐ Diabetes _____
☐ Hypertension _____ ☐ Cancer _____
☐ Stroke _____ ☐ Other: _____

Past Injury/Problem History

Date	Injury/Problem	Whom Seen	Treatment	Recovery Time
1.				
2.				
3.				

Present Injuries/Problems:

Date of Injury/Onset: _____/_____/_____ **Body Part(s):** _____

Onset: ◯ Gradual ◯ Sudden **Mechanism of Injury/Onset**: _____

Symptoms at the time of onset: _____

_____

Current symptoms: _____

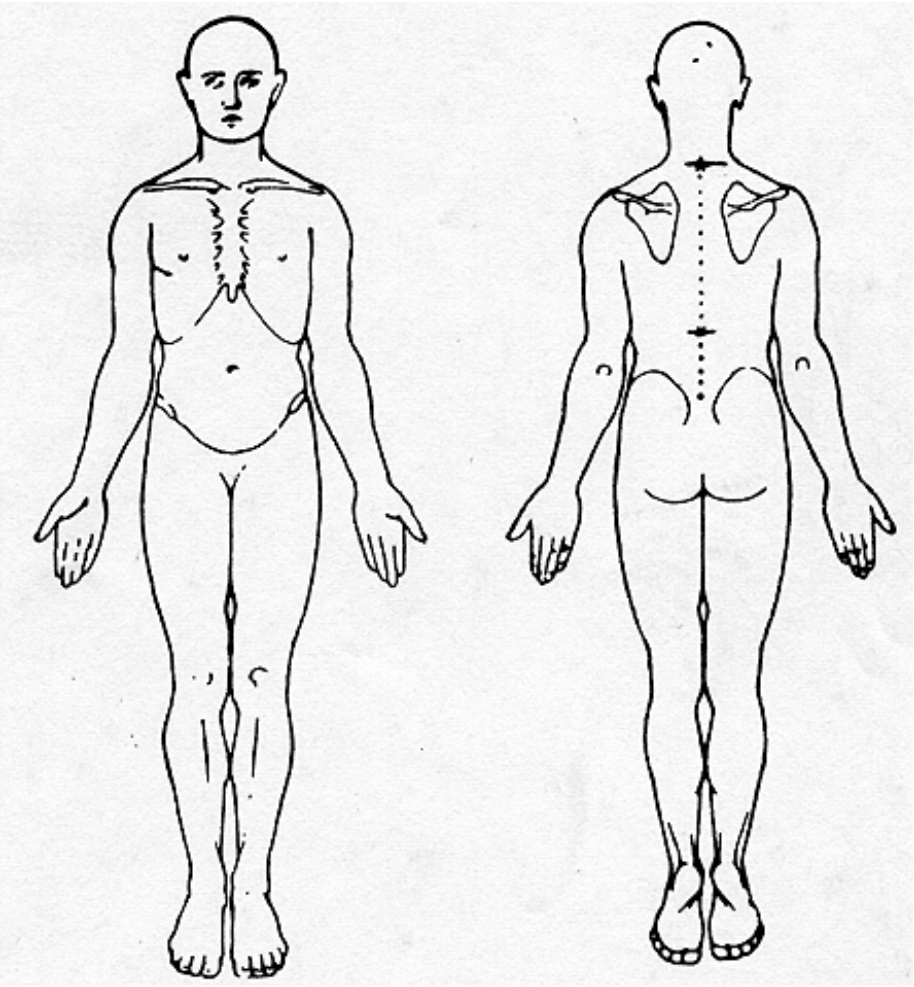
Positions/activities that **aggravate** symptoms: _____

_____

Positions/activities that **relieve** symptoms: _____

_____

Please mark on the drawings below where you feel pain.



Current Recreational / Fitness Activities	Frequency / Duration	Intensity (Mild, Moderate, Vigorous)

Goals for P.T. / Fitness

Short-term:_____

_____

_____

6 month:_____

_____

_____

Long-term:_____

_____