PEAK PERFORMANCE
Orthopedic & Sports Physical Therapy

PATIENT REGISTRATION

Name: ______________________ **Date of Birth:** __________ **Marital Status:** _____ **Gender:** _____ **SS #:** ______________________

Home Phone: ____________________ **Cell Phone:** ____________________ **Employer Phone:** ______________________

Patient's Address: ____
Address City State Zip Code

Email: ____

Emergency Contact: ____________________ **Phone:** ____________________ **Relationship:** __________________

Referring Physician: ____________________________ **Primary Care Physician:** ______________________________

Regarding appointment reminders, I prefer to be contacted via: ☐ email ☐ text ☐ voice call

Have you had outpatient physical therapy this year? ☐ Yes ☐ No **How many sessions?** ______________________

Employer: ____________________________ **Position:** ______________________________________

Do you have a case manager (worker's comp): ☐ Yes ☐ No **Name:** ________________ **Phone Number:** ______________

(Not Applicable to Worker's Compensation Claims)

Primary Insurance: ______________ **ID#:** ______________ **Group#:** ______________ **Policy Renewal Date:** ________

Secondary Insurance: ______________ **ID#:** ______________ **Group#:** ______________ **Policy Renewal Date:** ________

Name of Insurance Subscriber: ______________ **Subscriber's DOB:** __________ **Relationship to Patient:** ______________

Insurance Subscriber's Address (If different from above):

____
Street City State Zip Code

Authorization for Sharing PHI/Restriction (PHI- Personal Health Information)

Please Select: ☐ *Never release my PHI* ☐ *It is approved to release my PHI to the individuals listed below*

Name	*Relationship*	*Date of Birth*
______________	______________	______________
______________	______________	______________

Please specify the PHI that you wish to limit the use or disclosure of and state the specific restriction that you want to apply:

____

I hereby authorize the release of PHI as requested and hold harmless the releasing party from any legal liability which might arise from such release. I understand that this authorization is valid unless revoked by me in writing and would be subject to re-disclosure

Signature of Patient/Guardian: ____________________________ *Date:* __________ *Office Staff Initials:* __________

For a faster registration process, you may scan, upload, and email forms, copy of photo ID, and copies of insurance cards to admin@peakperformancetherapy.net.

Revised 11/8/16

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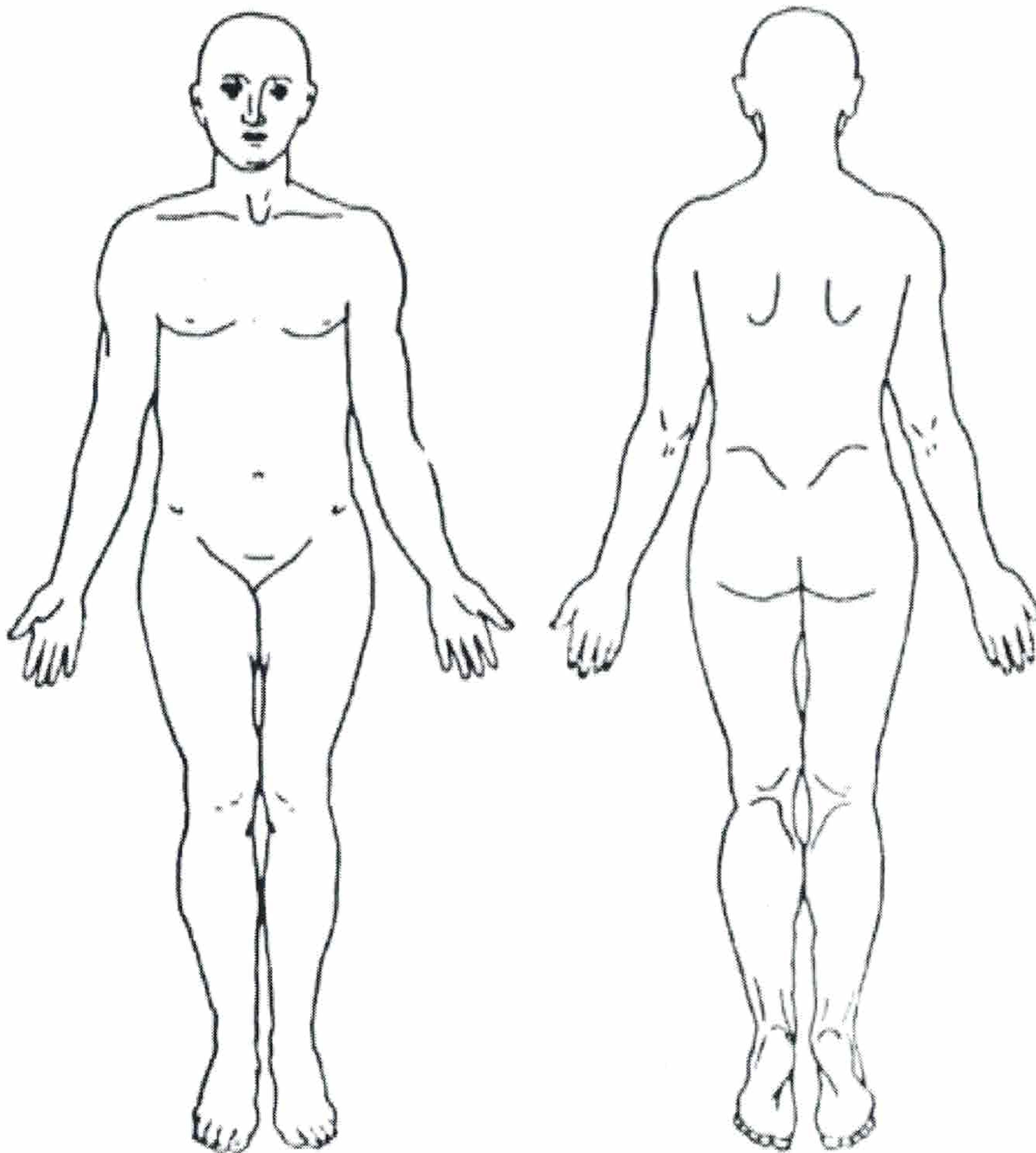
RANSFORD PAIN DRAWING

INSTRUCTIONS: **Use the symbols below** to describe your symptoms. If none of the following symbols describe your **present** symptoms, please leave blank. Indicate on the body diagram where your symptoms are located and what type of symptoms you feel at the **present** time. Do not indicate areas of pain which are not related to your **present** injury or condition that we are treating you for.

SYMBOL KEY: ***////*** (Stabbing) **XXX** (Burning) **OOO** (Pins and Needles) = = = = (Numbness)



Rate the Intensity of your Pain from 0-10 [0=none, 10=worst imaginable]

Present _____________ **Worst last 30 days**_____________ **Best last 30 Days**________________

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Name______________________________

MEDICAL HISTORY INFORMATION

What are we treating you for? ______________________________ **Date of Injury / onset of symptoms:** ________________

How did you get hurt? ☐ Fall ☐ Car Accident ☐ Lifting ☐ Sports ☐ Degenerative Process ☐ Cumulative Trauma ☐ Work Injury

☐ Other: ______________________________

Current work status: ☐ Off Work ☐ Light Duty Restrictions ☐ Normal Duty ☐ Retired ☐ Disabled

Nature of symptoms: ☐ Constant ☐ Intermittent ☐ Localized ☐ Diffuse ☐ Worse in am ☐ Worse in pm

What makes your symptoms worse? ______________________________

What makes your symptoms better?______________________________

What tests have you had for this condition? ☐ Xrays ☐ MRI ☐ CT scan ☐ Bone Scan ☐ EMG ☐ Discogram ☐ Other: ________________

Results: ______________________________

What procedures have you had for this condition? ☐ Spinal epidural ☐ Steroid injection ☐ Trigger point injection ☐ Surgery

Please list MEDICATIONS and DOSEAGES:

____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

Please mark all *Current* or *Past conditions*:

☐ Asthma
☐ Balance/Falling
☐ Bowel/Bladder Incontinence
☐ Blurred/double vision
☐ Cancer
☐ COPD / Emphysema
☐ Depression
☐ Diabetes(Type______)
☐ Difficulty swallowing
☐ Difficulty with speech
☐ Fibromyalgia
☐ Hard of Hearing
☐ Headaches
☐ Heart Attack
☐ Heart Disease
☐ Herniated Disc
☐ High Blood Pressure
☐ HIV (+)
☐ Learning Disability
☐ Low Blood Pressure
☐ Lupus
☐ Multiple Sclerosis
☐ Night Sweats
☐ Osteoarthritis
☐ Osteoporosis
☐ Parkinson's Disease
☐ Pregnancy
☐ Rheumatoid Arthritis
☐ Ringing in ears
☐ Seizures
☐ Shortness of Breath
☐ Spinal Conditions
☐ Spinal Cord Injury
☐ Spinal Surgery
☐ Stroke
☐ Sudden weight change
☐ Surgery
☐ Thyroid Disorder
☐ Other

Please provide additional details for any of the above checked boxes:

____

Please provide your current height and weight: ________feet _______inches ______ lbs

What are your goals for therapy? ______________________________

Next scheduled appointment with referring physician?______________________________

Whom may we thank for referring you to our facility? ______________________________

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