

Please complete and fax to 480-513-4867, or bring with you to your visit.

(Last) _____

PATIENT REGISTRATION

PATIENT Name: (First) _____ (MI) _____

Date of Birth: _____ SSN: _____ Sex: M F

Mailing Address: _____

City, State, Zip: _____

Phone: _____ Cell: _____ Email: _____

Employer: _____ Employer Phone: _____

Spouse/Guardian Name: (First) _____ (MI) _____ (Last) _____

Spouse/Guardian Date of Birth: _____ Spouse/Guardian SSN: _____

Spouse/Guardian Employer: _____ Spouse/Guardian Employer Phone: _____

Referring Physician: _____ Phone: _____

PRIMARY Insurance Co. Name: _____ Phone: _____

Insurance Co. Address: _____

Insured Name: _____ Insured Relationship to Patient: _____

Insured DOB: _____ Insured ID/Claim #: _____ Group #: _____

SECONDARY Insurance Co. Name: _____ Phone: _____

Insurance Co. Address: _____

Insured Name: _____ Insured Relationship to Patient: _____

Insured DOB: _____ Insured ID/Claim #: _____ Group #: _____

Please circle if this condition resulted from any of the following: Work Injury Motor Vehicle Accident Other Accident*

Please list the date of injury: _____ * If Other Accident please specify: _____

Is there currently a claim or lawsuit open or pending regarding this injury? YES NO

If yes, please provide the name and phone number to your attorney: _____

Who shall we call in an Emergency? _____ Phone: () _____

I understand and agree that I am ultimately responsible to ensure that all services needing pre-authorization by my insurance company are pre-authorized and that any balances for denied services, deductibles, coinsurance and copays are my responsibility to pay.

Responsible Party Signature: _____ Date: _____

Clinical Intake Form- Please complete and fax to 480-513-4867, or bring with you to your visit.

Name: _____ DOB: _____

Reason for Visit:

When did your current symptoms begin? (month/day/year) ___/___/___

Did you have a specific injury and if so please briefly describe: _____

Have you ever had your current symptoms before?: _____

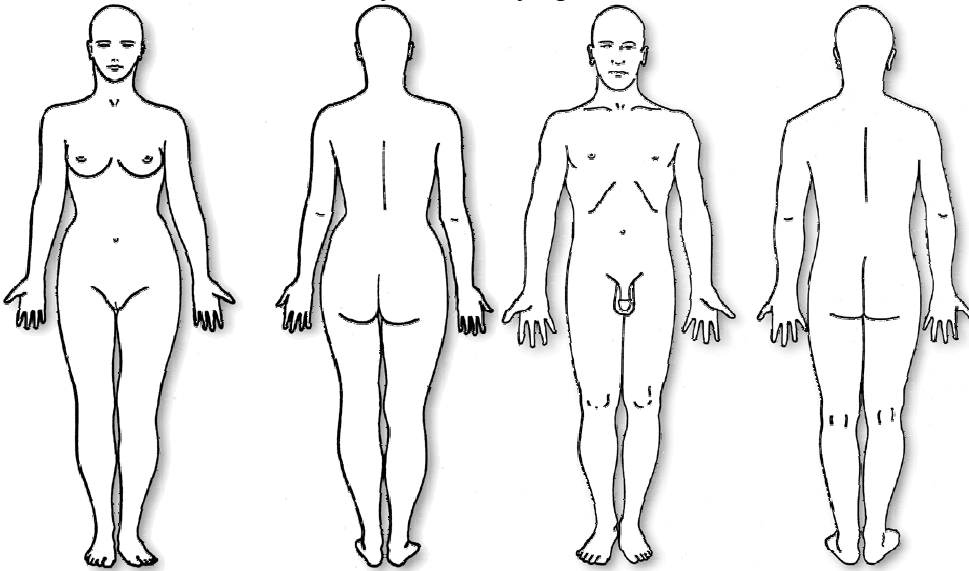
What makes your symptoms worse?: _____

What makes your symptoms better?: _____

Have you had any treatment for your current symptoms?: _____

Pain Description

Please shade the areas where you have symptoms:



Rate your current pain on a scale from by circling the corresponding number 0-10 (0= no pain; 10= requires emergency care)

	Current		Best		Worst
	10		10		10
	9		9		9
	8		8		8
	7		7		7
	6		6		6
	5		5		5
	4		4		4
	3		3		3
	2		2		2
	1		1		1
	0		0		0

Circle the words that most accurately describe your type of pain:

Shooting	Boring	Throbbing	Deep aching	Tingling
Dull	Burning	Stabbing	Sharp	Numbness

Personal Medical History: Please circle any of the following conditions which you currently have or have had:

	YES	NO
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Chronic obstructive pulmonary disease	<input type="checkbox"/>	<input type="checkbox"/>
Vascular diseases:	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (Rheumatoid/Osteo)	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Problems	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>
Psychological/emotional problems	<input type="checkbox"/>	<input type="checkbox"/>

Other Medical Problems: (Please list any other medical problems that have not been included)

Hospitalization/Operation: (Please list any hospitalizations or operations you have had & the date occurred)

	Date Occurred
_____	_____
_____	_____
_____	_____
_____	_____

Medication: (Please list any medication you are currently taking and the dosage)

Current Medical Tests: (performed within the last 2 months)

Lifestyle:

Do you smoke? _____. If Yes: How many packs do you smoke a day? _____

How many caffeinated beverages do you consume per week? _____

Do you exercise on a regular basis? _____ Type of activity/exercise: _____

Number of hours per week spent in physical activity/exercise: _____

Please rate your average stress level on a scale of 1-10 (0 = no stress, 10 = extreme stress): _____



CONSENT FOR TREATMENT

I understand that I have been referred for Physical Therapy treatment and rehabilitation to Back In Action of Scottsdale. My physical therapist at Back In Action of Scottsdale has described to me my individual treatment plan. I understand that I have the right to ask and have answered any questions prior to receiving any treatment, including risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. I also understand that I have the right to refuse any treatment prescribed by my physician or recommended by my therapist.

By signing this agreement, I consent to have Back In Action of Scottsdale provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Please sign and fax to 480-513-4867, or bring with you to your visit.

Patient/Guardian Signature: _____ Date: _____

Physical Therapist Signature: _____ Date: _____