Apex Physical Rehabilitation & Wellness

Sugar Land/Missouri City | Katy | Houston/Voss

OAKBEND PHYSICAL THERAPY
MISSOURI CITY

For best experience on your electronic device, use the free Adobe Reader. Before you begin, **SAVE the form on your computer,** CLOSE and **OPEN in your pdf reader.** Some mobile devices, web browsers, and managed networks may not support the interactive features of this form.

PRINT FORM | EMAIL FORM | CLEAR FORM

Registration

Sugar Land / Missouri City

1. ABOUT YOU

Last Name | First Name | **Gender (at birth)** ○ Male ○ Female ○ Prefer not to answer | Birthdate: mm/dd/yyyy

Middle Name or Initial | Age | Social Security Number: | Your height

Your weight | Mailing/Street Address | City | ZipCode

State | Home Phone Number: | Work Phone Number: | Cell Phone

E-mail Address | Employer's Name/Company | Employer's Address, City, State, Zip

What is your Occupation?

Status:

○ Widowed ○ Separated ○ Divorced ○ Married ○ Single ○ Minor

Spouse's Name

Do you have children? ○ No ○ Yes

How many Children?

2. INSURANCE INFORMATION

Primary Health Insurance Co. Name | Insurance Co. Address, City, State, Zip | Insurance Co. Phone #

Insured's ID# | Group #: (Plan, Local, or Policy #) | Insured's Name

Relation to Patient | Insured's Date of Birth mm/dd/yyyy | Insured's Employer

Secondary Insurance | Insurance Co. Address, City, State, Zip | Insurance Co. Phone #

Insured's ID# | Group #(Plan, Local, or Policy #) | Insured's Name

Insured's Relation to Patient | Insured's Date of Birth mm/dd/yyyy | Insured's Employer

3. ACCOUNT INFORMATION

Person responsible for account | What is your relation to patient | Billing Address, City, State, Zip

Social Security # 222-33-4444 | Driver's License # | Work Phone #

I hereby authorize assignment of my insurance rights and benefits to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Please click to acknowledge you agree with the above statement.

○ I do not Agree ○ I Agree

What is your preferred payment method?

○ Credit Card ○ Check ○ Cash

4. IN EVENT OF AN EMERGENCY

Relation to Patient

Home Phone #

Work Phone #

Cell Phone #

Whom should we contact?

Who is your Medical Doctor?

MD's Phone #

Medical History

Reason for today's visit:

Date your condition/accident occurred or approximate Date you noticed the problem?

Where did your injury occur?

Using a scale from 0 to 10, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Are you in pain?

◯ Yes ◯ No

The worst your pain has been during the past 24 hours:

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Your current level of pain while completing this survey:

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

The best your pain has been during the past 24 hours:

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

Did your injury occur during:

☐ Routine/Household activity ☐ Work ☐ Sports/play ☐ Auto Accident ☐ Slowly over time
☐ Chronic- I have had this more than 3 months

Please explain what happened:

Are your symptoms currently:

◯ Staying about the same ◯ Getting Better
◯ Getting Worse

How has your condition interfered?

How are you currently able to sleep at night due to your symptoms?

☐ Sleep only with medication ☐ Awakened by pain ☐ Difficulty falling asleep ☐ No problem sleeping

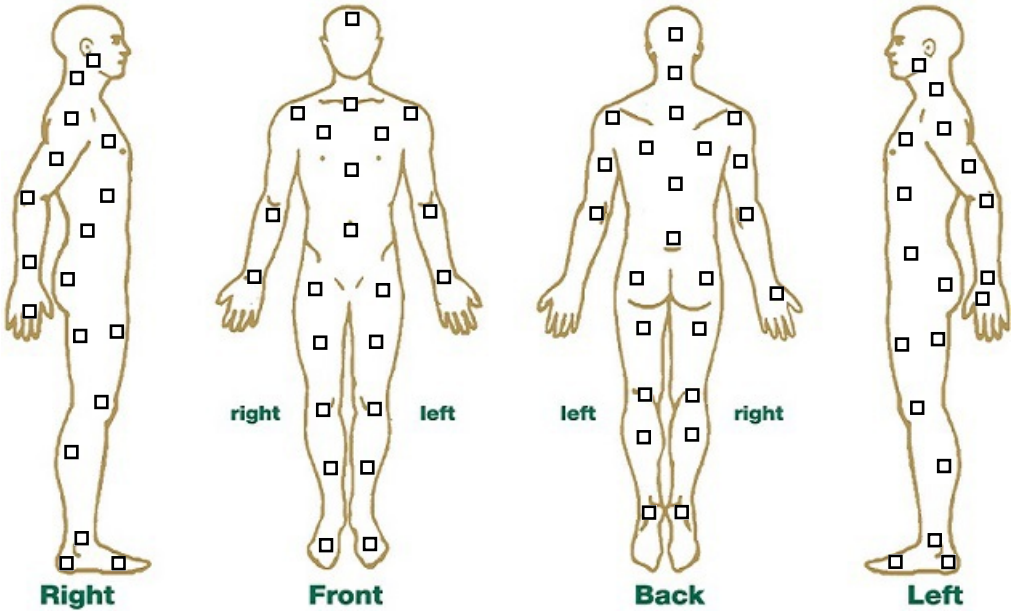
Is your condition interfering with your:

☐ Work ☐ Sleep ☐ Daily routine?

If you have experienced this problem in the past, when?

What treatment did you receive for this PAST problem?

How long did it take you to feel better?



List three positions or activities that make your symptoms worse:

When do your symptoms feel worse?

☐ After exercise ☐ Night ☐ Evening ☐ Afternoon ☐ Morning

When do your symptoms feel best?

☐ After exercise ☐ Night ☐ Evening ☐ Afternoon ☐ Morning

Are your symptoms currently:

○ Come and go ○ Are constant ◉ Are constant, but change with activity

List treatments or tests performed for this problem: (Chiropracitc, Injections, X-rays, MRI, blood work, etc.)

List three positions or activities that make your symptoms better:

Has condition been treated by a Medical Physician?

◉ Yes ◉ No

Medical Physician Contact Info

Has condition been treated by a Chiropractor?

◉ Yes ◉ No

If yes, please tell us the name of that practice.

Have you ever had physical therapy before?

◉ Yes ◉ No

Were you happy with your previous physical therapy experience?

◉ Yes ◉ No

Please list any medications you are taking? (pills, injections, skin patches, over the counter)

6. MEDICAL INFORMATION

Have you ever taken steroid medications for any medical conditions?

◉ Yes ◉ No

Are you taking any of the following medications?

☐ Nerve pills- Name/Dosage ☐ Pain killer(including aspirin)- Name/Dosage ☐ Muscle relaxers- Name/Dosage
☐ Blood Pressure - Name/Dosage ☐ Insulin- Name/Dosage ☐ Stimulants- Name/Dosage
☐ Anti-inflammatory-Name/Dosage ☐ Heart-Name/Dosage ☐ Please list all others with dosage

Have you ever taken blood thinning or anticoagulant medications for any conditions?

◉ Yes ◉ No

Please list any medications to which you may be allergic:

Have you RECENTLY noted any of the following (check all that apply)?

☐ Fatigue ☐ Headaches ☐ Changes in bladder function ☐ Changes in bowel function ☐ Falls ☐ Cough
☐ Difficulty swallowing ☐ Balance problems ☐ Fainting ☐ Heartburn/Indigestion ☐ Weight loss/gain
☐ Shortness of breath ☐ Dizziness/Lightheaded ☐ Nausea/Vomiting ☐ Diarrhea ☐ Muscle weakness
☐ Fever/Chills/Sweats ☐ Constipation ☐ Numbness or Tingling ☐ I don't have any of these problems

During the past month have you ever been feeling down, depressed or hopeless?

◉ Yes ◉ No

During the past month have you been bothered by having little interest or pleasure in doing things?

◉ Yes ◉ No

Is this something with which you would like help?

○ Yes ○ Yes, but not today ○ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?

○ Yes ○ No

Do you have or have you EVER had any of the following diseases, medical conditions or procedures?

☐ Cancer ☐ Pacemaker ☐ Chest Pain/Angina ☐ Glaucoma ☐ Thyroid Problems ☐ Liver problems ☐ Heart Surgery
☐ Stroke ☐ Heart Attack ☐ HIV+ / AIDS / ARC ☐ Lung Problmes ☐ Pelvic inflammatory disease
☐ Bladder/urinary tract infection ☐ Other arthritic conditions ☐ Circulation problems ☐ Osteoporosis
☐ Multiple sclerosis ☐ Rheumatoid arthritis ☐ Bone or joint infection ☐ Pneumonia ☐ Blood clots ☐ Depression
☐ Sexually transmitted Disease ☐ Kidney Problems/Infection ☐ Arthritis ☐ Artificial Bones/Joints/Implants
☐ Lower Back Problems ☐ Chemotherapy ☐ Difficulty Breathing ☐ Tuberculosis ☐ Emphysema / Asthma
☐ Sinus Problems ☐ Fainting/Seizures/Epilepsy ☐ Ulcers / Colitisemia ☐ Severe / Frequent Headaches
☐ Rheumatic Fever ☐ Psychiatric Problems ☐ High/Low Blood Pressure ☐ Anemia ☐ Diabetes ☐ Frequent Neck Pain
☐ Eye problem/infection ☐ Shingles ☐ Congenital Heart Defect ☐ Mitral Valve Prolapse ☐ Artificial Valves
☐ Alcohol / Drug Abuse ☐ Hepatitis ☐ Asthma

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

List any surgeries or other conditions for which you have been hospitalized, including dates. (For example: Appendectomy June 2008, Knee replacement July 2011 or enter none.)

Are you under doctor ordered work restriction? if so, explain.

Please list anything that you may be allergic to:

Are you latex sensitive?

○ Yes ○ No

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

☐ Not applicable ☐ Blood clots ☐ Depression ☐ High blood pressure ☐ Thyroid problems ☐ Stroke
☐ Heart problems ☐ Tuberculosis ☐ Diabetes ☐ Cancer

Do you take Supplements or Vitamins?

○ Yes ○ No

Do you exercise?

○ Yes ○ No

Hours per week

Do you smoke?

○ Yes ○ No

How much do you smoke?

How long have you smoked?

Are you wearing:

☐ Shoe lifts ☐ Inner soles ☐ Arch supports

Are you dieting:

○ No ○ Yes

Date Since Starting Diet

For women: Are you taking?

☐ Hormonal Replacement
☐ Birth control pills

Are you nursing?

○ Yes ○ No

Are you Pregnant?

○ Yes ○ No

How long have you been pregnant?

How many children have you had?

We invite you to discuss with us any questions regarding our services. The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand all the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that by typing my full legal name below, this constitutes my digital signature.

☐ I acknowledge my digital signature below.

Print your full name and sign:

X

Ip Address