REGISTRATION FORM

Please Print

***Referred by*:** ___________________________________ ***Date*:** _____________________

***Patient Name*:** ____ ***SSN*:** _____________________

First *Last*

***Street Address*:** ____

***City*:** _______________________________ ***State*:** _______ ***Zip Code*:** ___________________

Present Employer: ____________________________________ ***Work Phone:(____)*** _____________

Date of Birth*:** ____/_____/_____ ***Sex*(circle one) M F* ***Marital Status****(circle one) M S D W*

Cell Phone(________) ____________________ ***Home Phone(_______)*** ________________

***Emergency Contact*:** _________________________________ *Home/Cell #* ____________________

INSURANCE INFORMATION

***Spouse or Parent*:** ____________________________ ***Date of Birth*:** ____/_____/_____

***Primary Insurance*:** _______________________________________ *(**Circle one**) Self Spouse Parent*

***Secondary Insurance*:** ____________________________________ *(**Circle one**) Self Spouse Parent*

Do you have a co-pay? (circle one) Yes No If yes, how much? _____________

Is this related to a work accident? (circle one) Yes No

Is this related to an automobile accident? (circle one) Yes No

Do you want a copy of our Notice of Privacy Practices? (circle one) Yes No

I voluntarily give consent and permission for Cumberland Physical Therapy and its licensed therapists to administer medically necessary physical therapy services.
Signature: ______________________________________ Date: _____________________

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Cumberland Physical Therapy. I acknowledge that I am financially responsible for payment whether or not covered by insurance.
Signature: ____ Date: _______________________

Your Full Name: ______________________________

Please complete all of the following. Thank you.

What is the reason for your visit today?

Have you previously received treatment for this condition from:

☐ Physical Therapist ☐ Occupational Therapist ☐ Doctor ☐ Chiropractor ☐ Other: ________________

Briefly describe the treatment you received: ____

____

What is your main goal in coming to Physical Therapy? ____

____

Do you have any other symptoms/pain that are related or unrelated to your condition? ___________________

Pain Assessment

Do you have pain now? ☐ Yes ☐ No

If you answered yes above, please continue with questions below.
If you answered no, skip the section below.

Pain intensity: On a 0-10 scale (0 being no pain, 5 = moderate pain, 10 = worst pain you can imagine), how would you rate your pain? Average Pain Currently: ________ At its worst ________ At its best: _________

On a 0-10 scale, at what level of pain are you able to function as you want? ___________

Is your current pain: ☐ Constant ☐ Intermittent If intermittent, what percentage of the day do you have pain? _____
Location of pain: ____
Describe your pain (aching, burning, stabbing, etc.): ____
____

Do you have any of the following symptoms: ☐ Numbness ☐ Tingling ☐ Pins ☐ Needles ☐ Limb falling asleep
If so, what locations of your body? ____

What causes your pain to increase? ____

What relieves your pain? ____

What time of day is your pain worse: ☐ Morning ☐ Midday ☐ Evening ☐ Night

What everyday activities are limited by your current pain (work, driving, laundry)? _________________________

Personal Information / Social History

Hand dominance: ☐ Right ☐ Left

Work Status: ☐ N/A ☐ Full Duty ☐ Retired ☐ Off because of current injury: How long? ________

☐ Work with the following restrictions: ______________________________________
Duties/Physical Demands at Work: ____

Recreation Activities / Sports include: ____

Do you exercise regularly? ☐ Yes ☐ No If yes, how many times per week? ______________________

Do you currently smoke? ☐ Yes ☐ No If yes, how many packs a day ___ ? For how many years? _____

If not, were you a former smoker? ☐ Yes ☐ No When did you quit? _______________

Do you drink alcohol? ☐ Yes ☐ No Amount per week: _____ drinks per (check one) ☐ day ☐ week ☐ month

Overall, would you describe your sleep as: ☐ Good ☐ Fair ☐ Poor How many times per night do you wake? ______

Is the reason you wake up related to your current problem: ☐ Yes ☐ No

Do you currently take medication to sleep? ☐ Yes ☐ No

Your Full Name: ______________________________

Diagnostic Testing Please list any tests you have had for any condition in the last 3 months (x-ray, MRI, EMG, CT scan, etc.)

Current Medications
Please list all medications you are now taking, including over the counter and nutritional supplements.
If you have a list of medications, you may give it to us and omit this section.

Past Medical History
Please check current and past medical problems that you have been treated for.

☐ Cancer	☐ Osteoarthritis	☐ Loss of Bowel Control	☐ Bleeding Problems
☐ Diabetes	☐ Rheumatoid Arthritis	☐ Loss of Bladder Control	☐ Intestinal Disorders
☐ Heart Disease	☐ Headaches	☐ Epilepsy or Seizures	☐ Infections
☐ High Blood Pressure	☐ Osteoporosis	☐ Asthma	☐ Circulatory Problems
☐ CVA-Stroke	☐ Gout	☐ COPD or Emphysema	☐ Liver Problems / Hepatitis
☐ Pacemaker	☐ Metal Implants	☐ Chronic Bronchitis	☐ Thyroid Problems
☐ Gallbladder Problems	☐ Kidney Disease / Stones	☐ Currently Pregnant	☐ Multiple Sclerosis
☐ Depression / Anxiety	☐ Tuberculosis	☐ Parkinson's	☐ Fibromyalgia
☐ Other:			

Past Surgical History
Please list your previous surgeries and the year you had the surgery.

Surgery	**Year**

No-show and Late Cancellation Policy

When we make your appointment, we are reserving a room and therapist for your particular needs. We ask that if you must change your appointment, please give us at 24 hour notice. This courtesy makes it possible to schedule your reserved room and therapist time to another patient who would like it.

There is a charge of $25.00 for not showing up for scheduled appointments. Repeated cancellations or missed appointments will result in loss of future appointment privileges.

We feel that our patient's time is valuable. When your appointment is made, a room and therapist are reserved, your records are prepared, and the necessary equipment is readied for your visit. We try our best to be prompt getting you back for your scheduled appointment. We, of course, would appreciate the same courtesy from you.

Thank you,

CPT Staff

I have read, understand, and agree with the above mentioned policy.

Patient's Signature: ____________________________________

Unpaid Balances: Cumberland Physical Therapy reserves the right to refer unpaid due balances to third parties for collection. In the event that any past due balance is placed with a third party, I agree to pay any costs of such collection including agency fees, legal/attorney fees, and court costs.

Patient's Signature: ____________________________________