SEATTLE'S ELITE
PHYSICAL THERAPY

PATIENT REGISTRATION

Personal Information

Name _____ Today's Date _____ Date of Birth _____
Address _____ Email _____
_____ Would you like to receive email appointment reminders? Yes No
_____ Would you like to receive your exercises by email? Yes No

Home Phone _____ Social Security Number _____
Cell Phone _____ Employer _____
Work Phone _____

Marital Status: Single Married Other Partner's Name _____
Live Alone Live with family Live with roommates Other _____

Emergency Contact _____ Phone _____ Relation _____

Nature of Injury

Location of Injury/Symptoms _____ Date of Injury/ Symptom Onset_____
Is this a reoccurring injury? Yes No Date of prior occurrences _____
Do you have a referral from a physician for physical therapy? Yes No
Referring Physician _____ Primary Physician _____

Were you referred to us by someone other than your physician? _____

Insurance Information

Primary Insurance _____
Relationship to Insured Self Spouse Child
Cardholder's Name (if not self) _____ Date of Birth _____

Secondary Insurance _____
Relationship to Insured Self Spouse Child
Cardholder's Info (if not self) Name _____ Date of Birth _____
Address _____ Phone _____

Fill out the following only if applicable:
Labor and Industries Claim (Worker's Compensation)
Date of Accident _____ Claim Number _____
Employer Information: Name of Company _____
Address _____
Phone _____ Fax _____

Motor Vehicle Accident Claim (PIP)
Date of Accident _____ Claim Number _____
Insurance Company _____ Address _____
Billing/Claims Address _____

PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE ABOVE QUESTIONS

I hereby assign to Seattle's Elite Physical Therapy, Inc the release of any and all benefits from an insurer, third party payer, or other payer and authorize that such benefits be paid to Seattle's Elite Physical Therapy, Inc for services provided by Seattle's Elite Physical Therapy, Inc. I authorize the release of my health information to any party or entity responsible for payment of services rendered by Seattle's Elite Physical Therapy, Inc. I attest that, regardless of insurance coverage, I am responsible for the balance of my account. All account balances are due within 30 days of services rendered. If the balance is not paid within 30 days of the date of service, the balance will accrue a charge of 1% each month. I attest that the above information is complete and accurate to the best of my knowledge.

_____ _____ _____

Signature of Patient (or legal guardian) **Relationship of legal guardian** **Date**

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General Health Questionnaire

Patient: _____ Age: _____

Diagnosis or Problem Area:_____

Please complete this questionnaire so that we are able to provide you the best possible care. Check any problems below that you have now and/or have had trouble with in the past, and please check if you have a family history.

Self	Family		Self	Family	
____	_____	Chest Pain	____	_____	Osteoarthritis
____	_____	Heart Disease	____	_____	Rheumatoid Arthritis
____	_____	High/Low Blood Pressure	____	_____	Hepatitis
____	_____	High Cholesterol	____	_____	Blood Clots
____	_____	Poor Circulation	____	_____	Diabetes
____	_____	Difficulty Breathing	____	_____	Bleeding/Bruising Easily
____	_____	Tuberculosis	____	_____	Hearing Impairment
____	_____	Respiratory Disease	____	_____	Visual Impairment
____	_____	Numbness to Hands and Feet	____	_____	Skin Rash/Disease
____	_____	Head Injury	____	_____	Dizziness
____	_____	Stroke	____	_____	Cancer
____	_____	Seizures	____	_____	Allergies
____	_____	Difficulty with Balance	____	_____	Osteoporosis
____	_____	Frequent Falls	____	_____	Bowel/bladder Problems
____	_____	Blackouts	____	_____	Headaches

Have you experienced any of the following in the past 3 months?

Change in health	Yes	No	Change in appetite	Yes	No
Nausea/vomiting	Yes	No	Difficulty swallowing	Yes	No
Fever/chills/sweats	Yes	No	Night pain	Yes	No
Unexplained weight change	Yes	No	Unusual fatigue	Yes	No

Do you smoke? _____ If so, how much? _____
Do you drink alcohol?_____ If so, how much? _____
Do you exercise? _____ If so, how often? _____
Do you get short of breath with exertion (up/down stairs)? _____
Women, is there any chance of pregnancy?_____
Do you have any other orthopedic injuries? _____
_____
Please list any surgeries or hospitalizations: _____
_____
Please list (or bring in a copy of) any medications or supplements you are currently taking:_____
_____
_____

Do you have any other special problems/concerns we should know about?
_____
_____

_____ _____ _____

Patient Signature Parent / Guardian Signature Date

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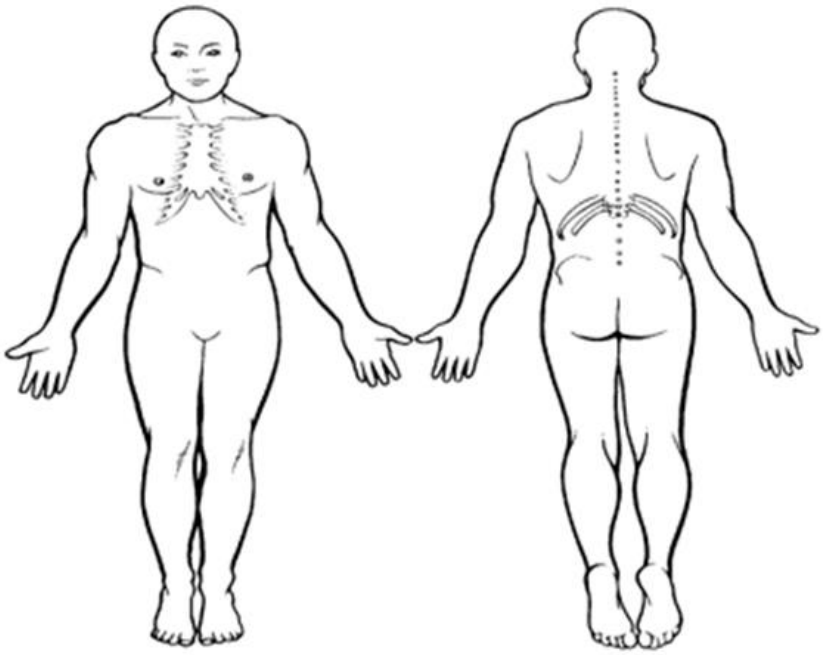
On the scales below, please circle the number which best represents the severity of your pain.

Currently:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable
Least amount of pain in the last **48 hours**:
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable
Most amount of pain in the last **48 hours:**
No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Body Chart:

Please mark the areas where you feel pain on the chart to the right.



Please circle the number below which best represents your **overall average level of function**.

Cannot do anything 0 1 2 3 4 5 6 7 8 9 10 Able to do everything

What makes your symptoms better?

_____

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem. List them below:

1) _____

2) _____

3) _____