KEATING
PHYSICAL THERAPY

New Patient Registration

Name:_____

Address:_____

City:_____State:_____ Zip code:_____

Primary telephone #:_____ Check one:__ home __ work __cell

Secondary telephone #:_____ Check one:__ home __ work __ cell

Email:_____

Gender : Male Female Date of Birth:_____

Referred by:_____ Check one:__ physician__ family__ friend __co-worker

Emergency contact:_____

Phone:_____ Relationship:_____

List Medications:

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PHYSICAL THERAPY

Medical History

Previous Surgical History:

Pain level: No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

Pain type: (circle all that apply)

Dull Achy Sharp Constant Shooting/Radiating Intermittent

Does the pain wake you up at night? Yes No

What activities increase your symptoms?

What activities decrease your symptoms?

Circle all conditions that apply to your medical history:

Cardiovascular: Heart attack High blood pressure High cholesterol Other

Neurological: Seizures Multiple Sclerosis Parkinson's Disease Stroke Other

Pulmonary: Emphysema Bronchitis Asthma Other

Endocrine: Diabetes Thyroid Disease Other

Infectious Disease: HIV Hepatitis Other

Gastrointestinal: Ulcer Crohn's Other

Oncologic: Cancer

Hemotologic: Anemia Sickle cell Other

Auto immune: Lupus Celiac Other