ALPINE
PHYSICAL THERAPY AND SPORTS CARE

PATIENT REGISTRATION

Alpine Physical Therapy & Sports Care, P.C. is committed to providing outstanding care in the areas of rehabilitation, sports training, injury prevention, and overall health and fitness. To assist us in providing these services and in meeting our legal obligations as a healthcare provider, we kindly request that you complete this form.

FIRST NAME: _____ MIDDLE INITIAL: ____ LAST NAME: _____

NICKNAME: _____

DATE OF BIRTH: _____

SEX ASSIGNED AT BIRTH: MALE _____ FEMALE _____ GENDER IDENTITY: _____

MARITAL STATUS:

SINGLE _____ MARRIED _____ OTHER _____

EMPLOYMENT STATUS:

FULL-TIME _____ PART-TIME _____ EMPLOYER NAME: _____

RETIRED _____ UNEMPLOYED _____

STUDENT STATUS:

FULL-TIME _____ PART-TIME _____ NOT A STUDENT _____

CONTACT INFORMATION:

MAILING ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

HOME PHONE #: _____ MOBILE PHONE #: _____

WORK PHONE #: _____ EMAIL: _____

WHAT IS YOUR PREFERRED METHOD OF GENERAL COMMUNICATION? (Please check one.)

HOME PHONE _____ MOBILE PHONE _____ TEXT _____ EMAIL _____

CAN WE LEAVE A MESSAGE AT YOUR PREFERRED METHOD OF COMMUNICATION? YES _____ NO _____

WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS? YES _____ NO _____

IF "YES," PLEASE CHOOSE A METHOD OF REMINDERS YOU WOULD LIKE. (Please check one.)

VOICEMAIL – HOME PHONE _____ VOICEMAIL – MOBILE PHONE _____ TEXT – MOBILE PHONE _____ EMAIL _____

EMERGENCY CONTACT INFORMATION:

NAME: _____

RELATIONSHIP TO PATIENT: _____

PHONE #: _____

CAN WE DISCUSS YOUR CARE WITH THE ABOVE PERSON? YES _____ NO _____

INSURANCE INFORMATION:

PRIMARY INSURANCE CO.: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S D.O.B.: _____

SECONDARY INSURANCE CO.: _____

POLICY HOLDER'S NAME: _____ POLICY HOLDER'S D.O.B.: _____

HAVE YOU RECEIVED ANY IN-HOME MEDICAL SERVICES OR BEEN DISCHARDED FROM AN IN-PATIENT FACILITY WITHIN THE PAST 30 DAYS? YES _____ NO _____

IF "YES," WHAT ORGANIZATION PROVIDED THESE SERVICES AND WHAT WAS YOUR DISCHARGE DATE?

_____

HAVE YOU RECEIVED OUTPATIENT PHYSICAL THERAPY, SPEECH THERAPY, OR OCCUPATIONAL THERAPY AT ANOTHER LOCATION WITHIN THE PAST YEAR? YES _____ NO _____

IF "YES," PLEASE LIST THE PROVIDER AND DIAGNOSIS.

_____

MEDICAL HISTORY

PLEASE CHECK ANY CONDITIONS THAT YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST.

ALZHEIMER'S ___
ASTHMA ___
BACK PROBLEMS ___
CARDIOVASCULAR DISEASE ___
CATARACTS ___
CAUDA EQUINA SYNDROME ___
CEREBRAL VASCULAR ACCIDENT ___
CURRENT INFECTION ___
DEPRESSION ___
DIABETES MELLITUS TYPE 1 ___
DIABETES MELLITUS TYPE 2 ___
DIZZINESS ___
EPILEPSY ___
FAINTING ___
FIBROMYALGIA ___
FRACTURE(S) ___
GLAUCOMA ___
GOUT ___
HEPATITIS ___
HERNIA ___
HIGH BLOOD PRESSURE ___
HISTORY OF CANCER ___
HUNTINGTON'S ___
IMMUNOSUPPRESSION ___
INFECTIOUS DISEASE ___
KIDNEY DISEASE ___
LIVER DISEASE ___
LUNG PROBLEMS ___
LUPUS ___
LYME DISEASE ___
MULTIPLE SCLEROSIS ___
MUSCULAR DYSTROPHY ___
NEUROLOGICAL ISSUES ___
OBESITY ___
OSTEOARTHRITIS ___
OSTEOPOROSIS ___
PACEMAKER ___
PARKINSON'S ___
RECENT ONSET BLADDER DYSFUNCTION ___
RHEUMATOID ARTHRITIS ___
RINGING IN EARS ___
SHORTNESS OF BREATH ___
STOMACH ISSUES ___
THYROID PROBLEMS ___
TRAUMATIC BRAIN INJURY ___
OTHER _____

DO YOU HAVE A FAMILY HISTORY OF HEART DISEASE IN A PARENT OR SIBLING BEFORE AGE 55? YES ___ NO ___

DO YOU HAVE A FAMILY HISTORY OF CANCER IN A PARENT OR SIBLING BEFORE AGE 55? YES ___ NO ___

DO YOU SMOKE? YES ___ NO ___

HAVE YOU EVER SMOKED? YES ___ NO ___

DO YOU HAVE A PERMANENT DISABILITY RATING? YES ___ NO ___

ARE YOU PREGNANT, LACTATING, ANTICIPATING BECOMING PREGNANT, OR HAVE YOU BEEN PREGNANT WITHIN THE PAST YEAR? YES ___ NO ___ N/A ___

HOW WOULD YOU DESCRIBE YOUR CURRENT HEALTH? EXCELLENT ___ VERY GOOD ___ GOOD ___ FAIR ___ POOR ___

PLEASE LIST ANY PAST SURGERIES, HOSPITALIZATIONS, OR OTHER SERIOUS DISEASE(S).

_____

_____

_____

PLEASE LIST ANY ALLERGIES.

_____

_____

_____

CURRENT MEDICATIONS:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____

PRINTED NAME: _____ DATE: _____