BONITA SPRINGS SPORTS &
PHYSICAL THERAPY CENTER, INC.

REGISTRATION FORM

PLEASE PRINT

FIRST:	LAST:	INITIAL:
LOCAL ADDRESS:	e-mail	
CITY:	STATE:	ZIP:
PHONE:	2nd #:	CELL:
DATE OF BIRTH:	SEX: MALE / FEMALE	
SOCIAL SECURITY #:	MARITAL STATUS: M / W / S / D	
EMERGENCY CONTACT:	PHONE:	
NORTHERN ADDRESS:	PHONE:	
CITY:	STATE:	ZIP:
DOCTORS NAME:	Dr. PHONE #:	
DATE OF SURGERY:		
HAVE YOU HAD ANY PHYSCIAL THERAPY SOMEWHERE ELSE THIS YEAR? YES / NO		
HAVE YOU HAD ANY HOME HEALTH THIS YEAR? YES / NO		
IF YES, WHEN WERE YOU DISCHARGED?		
HOME HEALTH COMPANY :		

If this is an Auto Accident, most auto insurance carriers only pay at 80%. You will be responsible for the remaining 20%. Your Health Insurance may pay that remaining 20%. Please give the front office your health insurance information. We do not take "letter of protection".

BONITA SPRINGS SPORTS AND PHYSICAL THERAPY CENTER
PAST MEDICAL HISTORY FORM

Your Physician has referred you for Physical Therapy services. Thank you for answering the following questions so that we may administer treatment safely and effectively.

NAME:_____ AGE:_____

1. **Have you had any other physical therapy services this year, INCLUDING ANY MEDICAL PERSON OR SUPPLY COMPANY COMING TO YOUR HOME?_____**
   If yes, when and why?_____
   _____

2. **Any surgery for the problem you are here for today? _____**

3. **List any major operations within the last 5 years._____**

4. **Do you have a cardiac pacemaker, defibrillator or heart problem?**
   _____

5. **Do you have high blood pressure?_____**

6. **Do you have diabetes?_____**

7. **Have you ever had seizures or convulsions?_____**

8. **Are you pregnant?_____**

9. **Have you had any cancer?_____**

10. **Do you have a thyroid condition?_____**

11. **Do you have asthma or any other breathing problems?_____**

12. **Are there any other important health problems we should know about to ensure safe physical therapy?_____**

13. **Do you have any allergies to disinfectants, soaps, lotions, gels, latex or tape adhesives?_____**

14. **At the present time, would you say your OVERALL health is EXCELLENT, VERY GOOD, FAIR OR POOR?**

15. **Do you live alone? With a spouse? With a caregiver? Other:_____**

16. **What medications are you now taking?_____**
    _____