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, INC.
PAST MEDICAL HISTORY FORM

PATIENT NAME:_____ DOB:_____

1. **HAVE YOU HAD ANY OTHER PHYSICAL THERAPY SERVICES THIS YEAR? _____**
   ***** If yes, when and how many treatment sessions?_____**
   *****Very Important: Medicare CAP &/or Medicare Consolidated Billing**

2. **HAVE YOU HAD ANY MEDICAL PERSON IN YOUR HOME THIS YEAR? (Nurse, Home Physical Therapist, Supplies Delivered? _____ *** If yes, how many treatment sessions and when was their LAST VISIT? _____**
   *****Very Important: Medicare CAP &/or Medicare Consolidated Billing**

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

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

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

6. **Do you have ANY implanted Electrical Stimulators? _____**

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

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

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

10. **Are you pregnant?_____**

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

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

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

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

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

16. **Would you say your OVERALL health is EXCELLENT, VERY GOOD, FAIR OR POOR?**

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

18. **Do you have stairs at home (ANY steps at all)? _____**

19. **What medications are you now taking specifically FOR THIS PROBLEM? _____ _____(Note: Medicare requests that physical therapist has a COMPLETE list of all medications you are taking (prescription, over-the-counter, supplements, etc) (drug/dose/freq/route/reason). Even if you are not a Medicare patient, please provide this information.)**

Thank You!

THERAPIST'S SIGNATURE_____ DATE_____

CURRENT MEDICATION LIST

Medicare requests that we have a COMPLETE list of all medications you are taking. This includes prescription, over-the-counter, herbals, vitamin/mineral dietary (nutritional supplements), etc. to be on record.

PLEASE PROVIDE THE FOLLOWING: **THANK YOU!!**

NAME: _____

DATE OF BIRTH: _____

DRUG NAME	DOSAGE	FREQUENCY	ROUTE (Oral, Inject, Patch, Etc.)	REASON YOU TAKE THIS DRUG