TEXAS STAR
REHAB AND PERFORMANCE CENTER

# PATIENT REGISTRATION FORM

*Please Print*

Patient Name:_____ Gender: ☐ Male ☐ Female

Birth Date:_____ Age:_____ Social Security #:_____

Address:_____ City, State, Zip:_____

Home Phone #:_____ Cell Phone #:_____

Email:_____

Would you like to receive appointment reminders via email: ◯ Yes ◯ No

***If under 18,*** Parent/Guardian:_____ Relationship to Patient:_____

Parent/Guardian Social #:_____ Parent/Guardian Birth Date:_____

Emergency Contact: Relationship/Phone:_____

Do you have a prescription from a physician or provider for physical therapy? ◯ Yes ◯ No

If yes, who is the referring physician?_____ Return to Doctor Date?_____

How did you hear of Texas Star Rehab and Performance?

☑ Friend/Family/Acquaintance
☐ Former Patient
☐ Website/Social Media
☐ Physician
☐ Free Injury Screening
☐ Employee
☐ Insurance Company/Employer
☐ Sports Club/Coach
☐ Location/Signage
☐ Advertisement
☐ Others

Are you seeking Physical Therapy because of a sports injury through a school or club sport? ◯ Yes ◯ No

Person/School/Team that referred you:_____

Are you seeking Physical Therapy because of a Work-Related Accident? ◯ Yes ◯ No

Employer Name:_____ Phone:_____

Employer Address:_____

**INSURANCE INFORMATION** *(To be completed even if insurance card on file)*

**Primary Insurance**

Insurance Co Name:_____

Policy Holder:_____

Policy Holder Birth Date:_____

Relationship to Patient:_____

**Secondary Insurance**

Insurance Co Name:_____

Policy Holder:_____

Policy Holder Birth Date:_____

Relationship to Patient:_____

Patient/Guardian Signature:_____ Date:_____

# PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Gender: ☐ Male ☐ Female Date: _____

Referring Physician: Return Visit Date: _____

Body Part: _____ Date of Injury: _____ Date of Surgery: _____

Occupation: Work Status: ◯ FT ◯ PT ◯ Unemployed

Hobbies: _____ Prior Treatment: _____

Height: _____ Weight: _____

**What is the nature of the current injury?**

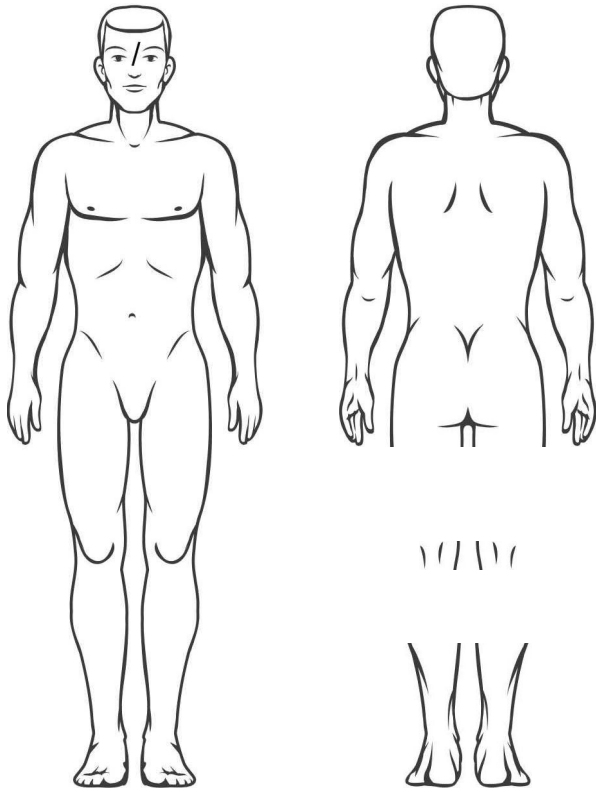
| | | | |
|---|---|---|---|
| ☐ Work Related | ☐ Chronic/Reoccurring | ☐ Fall | ☐ MVA |
| ☐ Recreational | ☐ Lift or Carry | ☐ Insidious | ☐ Surgery |

What is your pain rating in the last 24 hours? 0-10 Numeric Pain Rating Scale

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST POSSIBLE PAIN

**Please use the diagram provided to mark where your symptoms are currently.**



**Symbols to Use**

| | |
|---|---|
| (@) Aching | ( X ) Burning |
| ( / ) Stabbing | ( = ) Numbness |
| ( O ) Pins & Needles | ( # ) Radiates |

My symptoms are made better by: _____

My symptoms are made worse by: _____

My symptoms are:

☐ Constant ☐ Intermittent ☐ Chronic ☐ New

Are your work or activities of daily living limited?

☐ Yes ☐ Partial ☐ No

In addition to this paperwork, you will complete a functional outcomes scale.

# PATIENT MEDICAL HISTORY FORM (CONTINUED)

What is your goal for physical therapy? _____

How often do you exercise more than 20 minutes per day?

☐ 1x/wk ☐ 2x/wk ☐ 3x/wk ☐ 4x/wk ☐ 5x/wk ☐ 6x/wk ☐ 7x/wk

Do you smoke? ☐ Yes ☐ No

List any recent Diagnostics (*Xray, MRI, CT Scan, EEG, EMG, Injections*):

_____

Do you have any allergies to latex, cold, heat or medications? ☐ Yes ☐ No If yes: _____

Are you on any medications? ☐ Please see attached list provided by the patient.

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Are you on any blood thinners? ☐ Yes ☐ No INR: _____

Have you had Home Health Care or a stay with an Inpatient Facility in the last 30 days? If so, please state where:

_____

Have you been discharged? ☐ Yes ☐ No What was the date you were discharged from care? _____

Have you fallen in the last year? ☐ Yes ☐ No If yes, how many times? _____

Did you sustain an injury when you fell, and if so, please describe: _____

Under what circumstances did you fall? (e.g. location, using assistive device, transferring, etc.)

_____

**Past Medical History**

Have you recently noted any of the following? (*check all that apply*)

| | | | |
|---|---|---|---|
| ☐ Changes in Bowel or Bladder | ☐ Fatigue | ☐ Nausea/Vomiting | ☐ Shortness of Breath |
| ☐ Constipation | ☐ Fever/Sweats/Chills | ☐ Numbness/Tingling | ☐ Unexplained Weight gain/loss |
| ☐ Difficulty Swallowing | ☐ Hearburn/Indigestion | ☐ Pain that wakes you at night | ☐ Unexplained Cough |
| ☐ Dizziness/Lightheaded | ☐ Incontinence | ☐ Rapid Heart Rate/Palpitations | ☐ Visual Changes |
| ☐ Fainting | ☐ Muscle Weakness | ☐ Recent Onset of Headaches | |

☐ Prior surgeries. Please describe: _____

Have you ever been diagnosed with any of the following? (*check all that apply*)

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Chest Pain or Angina | ☐ High/Low Blood Pressure | ☐ Stroke/CVA/TIA |
| ☐ Asthma | ☐ Chronic Headaches | ☐ Lung Disease/COPD/ARDS | ☐ TB/HIV/Hepatitis A,B,C |
| ☐ Back Pain *(Degenerative, Stenosis, Herniation)* | ☐ Congestive Heart Failure/Heart Attack | ☐ Neurological Disease *(MS, Parkinson's)* | ☐ Thyroid Condition |
| ☐ Bladder/Urinary/Kidney Disease | ☐ Depression/Anxiety/Panic Disorders | ☐ Osteoarthritis/Rheumatoid Arthritis | ☐ Vascular/Circulation Problems/ Blood Clots |
| ☐ Bone/Joint infections | ☐ Diabetes Type I/Type II | ☐ Pneumonia | ☐ Visual or Hearing Impairments |
| ☐ Cancer *(any)* | ☐ GI Disease *(Liver, Ulcer, Hernia, Reflex, Gall Bladder)* | ☐ Seizures or Epilepsy | ☐ Other_____ |

**The above information I have provided is complete, true and correct to the best of my knowledge.**

Patient/Guardian Signature: _____ Date: _____