TRANS WORLD THERAPY

PATIENT REGISTRATION AND EVALUATION

PATIENT INFORMATION Date _____

Name _____ Sex □ M □ F Age _____

Address _____

City _____ State _____ Zip _____

Email _____ Birthdate _____

Home Phone (_____)_____Cell Phone (_____)_____

Marital Status _____ Spouse's Name _____

Best time and place to reach you: _____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home Phone (_____)_____ Cell Phone (_____)_____

HEALTH HISTORY

What treatment have you already received for your condition?

□ Medication □ Surgery □ Physical Therapy □ Other _____

List tests/ procedures performed for your condition: _____

_____

Place a check mark to indicate if you have had any of the following:

□ AIDS/HIV
□ Alcoholism
□ Anemia
□ Appendicitis
□ Arthritis
□ Bleeding Disorders
□ Breast Lump
□ Bronchitis
□ Cancer
□ Chemical Dependency
□ Emphysema
□ Epilepsy
□ Fractures
□ Goiters
□ Gout
□ Heart Disease
□ Hepatitis
□ Hernia
□ Herniated Disk
□ Herpes
□ High Blood Pressure
□ High Cholesterol
□ Kidney Disease
□ Liver Disease
□ Migraine Headaches
□ Mononucleosis
□ Osteoporosis
□ Pacemaker
□ Parkinson's Disease
□ Pinched Nerve
□ Polio
□ Prostrate Problem
□ Psychiatric Care
□ Rheumatoid Arthritis
□ Rheumatic Fever
□ Sexually Transmitted Disease
□ Stroke
□ Suicide Attempt
□ Thyroid Problems
□ Tuberculosis
□ Tumors, Growths
□ Ulcers
□ Vaginal Infections
□ Other

Are you pregnant? □ No □ Yes (Due Date: _____)

Injuries / Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
_____	_____	_____
_____	_____	_____
_____	_____	_____

PATIENT EVALUATION

Diagnosis: _____

_____

History of Injury: _____

_____

_____

Reason for visit or major complaint:

_____

Is this condition getting progressively worse?

□ Yes □ No □ Unknown

Rate the severity of your pain on a scale of 1 to 10 (10 being the most painful): _____

Describe the pain:

_____

_____

How often do you have this pain?

_____

Does it interfere with your

□ Daily Routine □ Recreation □ Work □ Sleep

Activities that are painful to perform:

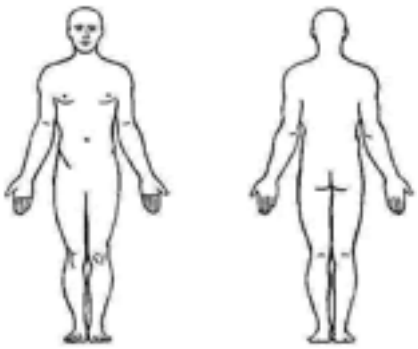
□ Sitting □ Standing □ Walking

□ Bending □ Lying Down

Work: □ Sedentary □ Active □ Retired

Recreation: □ Sedentary □ Active

Area of Injury: _____



Sleep Condition: _____

Sitting Condition: _____

Lifting: _____

Gait / Walking Condition:

_____

_____

ADL / Limitations / Challenges:_____

_____

_____

Appearance / Scars: _____

_____

_____

_____

Swelling: _____

Sensation: _____

_____

Posture: _____

_____

MMT / ROM:

	AROM	PROM	Strength

Additional Notes:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Plan of Care/ Goals:_____

_____

_____

PT Treatment: _____

_____

_____

Physical Therapist Signature: _____

Irene Hujsa, PT