FORT LEE PHYSICAL THERAPY

PATIENT REGISTRATION FORM (PLEASE PRINT CLEARLY)

PATIENT MEDICAL HISTORY Medical Condition		Please Circle
1.	History of Heart Problems / Historia de Problemas Cariacos	YES or NO
2.	Pace-Maker / Marka-Pasos (De Corazon)	YES or NO
3.	High Blood Pressure / Presion Alta	YES or NO
4.	Cancer / Cancer	YES or NO
5.	Tumors or Cysts Removed / Tumores o Lunares Malignos Extraidos	YES or NO
6.	Tuberculosis / Tuberculosis	YES or NO
7.	Skin Disorders / Desordenes de la Piel	YES or NO
8.	HIV Positive / SIDA	YES or NO
9.	Lung Disease / Problemas Pulmonares	YES or NO
10.	Asthma / Asma	YES or NO
11.	Are you presently pregnant / Esta ahora Embarasada?	YES or NO
12.	Headaches / Frecuente Dolores de Cabeza	YES or NO
13.	Dizziness / Mareos	YES or NO
14.	Blurred Vision / Vision Nublada	YES or NO
15.	Vomiting or Nausea / Frecuente Vomito o Nausia	YES or NO
16.	Numbness / Falta de Sensacion	YES or NO
17.	Arthritis / Artritis	YES or NO
18.	Osteoporosis / Osteoporosis	YES or NO
19.	Internal Implants (Metal or Plastic) / Implantes Internos (de Metal o Plasticos)	YES or NO
20.	Diabetes / Diabetis	YES or NO
21.	Hepatitis / Hepatitis	YES or NO
22.	Circulation Problems / Problemas con la Ciculacion	YES or NO
23.	Sensitivity to Heat or Ice Pack / Sensibilidad al Calor o al Frio	YES or NO
24.	Have you fallen within the past 6 months?	YES or NO
25.	Height:	Weight:

Pain Level: 0 = No Pain 10 = Extreme pain

26. Please rate your ***current*** pain

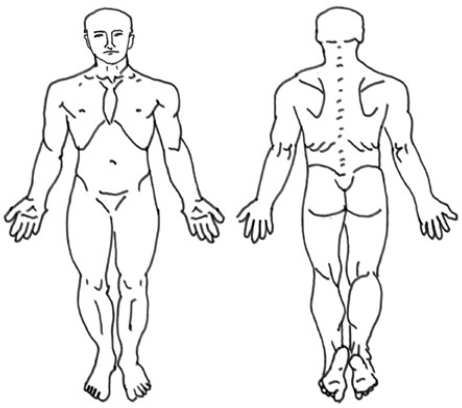
0 1 2 3 4 5 6 7 8 9 10

27. Please rate your ***worst*** pain in the last week

0 1 2 3 4 5 6 7 8 9 10

28. Please rate your ***least*** pain in the last week

0 1 2 3 4 5 6 7 8 9 10



Please shade the areas where you are having pain.

Patient Signature _____ Date _____

Parent/Guardian (if minor) Signature _____ Date _____