Registration

Patient Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ E-mail _____

Birthdate _____/_____/_____ Social Security Number _____/_____/_____

Marital Status _____ Employer _____

Work Address _____ City _____ State _____ Zip _____

Occupation _____ Work Phone _____

Diagnosis or Describe your problem

_____

_____

Referring Physician _____

Address _____ City _____ State _____ Zip _____

Phone _____

Emergency Contact Name _____

Address _____ City _____ State _____ Zip _____

Phone _____

Insurance and policy numbers _____

_____

_____

How did you hear about Wenning Physical Therapy? _____

Pain Questionnaire

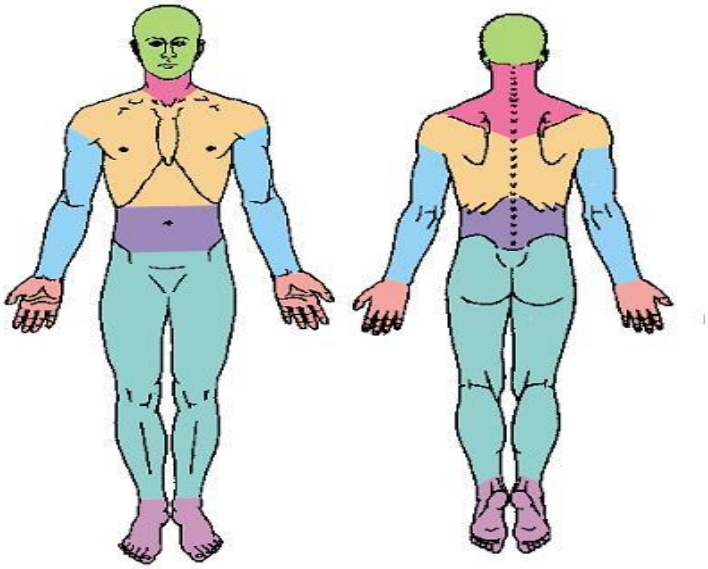
When did this episode begin? _____/_____/_____ Did it begin ☐ Gradually ☐ Suddenly

Did it begin with ☐Bending ☐Reaching ☐Lifting ☐ Twisting

☐Falling ☐Motor Vehicle Accident ☐Other _____

What happened? _____

Where is the pain? Use the diagram and symbols to show where your pain is located.



AAAA Ache

XXXX Burning

OOOO Numbness

•••• Pins/Needles

//// Stabbing

Circle the number that best represents your level of pain.

	No Pain										Worst ever
What is it right now?	0	1	2	3	4	5	6	7	8	9	10
What is the best?	0	1	2	3	4	5	6	7	8	9	10
What is the worst?	0	1	2	3	4	5	6	7	8	9	10

What, if anything, makes it worst? _____

What, if anything, makes it better? _____

Have you had this problem before? _____

What medications are you taking for this pain? _____

Have you seen anyone else for this problem?

☐Doctor ☐Physical Therapist ☐Chiropractor ☐Holistic ☐Other

Medical History

Have you ever had?

☐High Blood Pressure	☐Diabetes	☐Cancer
☐Chest Pain (Angina)	☐Hernia _____	☐Skin Allergies
☐Heart Attack	☐Gastrointestinal problems	☐Depression
☐Other Cardiac Problems	☐Arthritis	☐Stroke
☐Phlebitis/blood clots	☐Osteoarthritis	☐Asthma/lung problems
☐Infectious Disease (HIV/Hepatitis/etc)		

Are you: ☐ pregnant Do you : ☐have a pacemaker ☐have metal implants

Please list any prior surgeries: _____

_____

Please list any current medications or over the counter remedies: _____

Review of systems (Please check next to any symptom you have had in the past year)

Constitutional
□ Fevers, chills, sweats
□ Change in appetite
□ Pain that awakens you at night
□ Excessive fatigue
□ Recent unintended weight loss

Eyes, Ears, Nose & Throat
□ Recent vision changes
□ Glaucoma
□ Fragments in eyes
□ Nosebleeds
□ Hearing loss
□ Poor Balance

Cardiovascular
□ Chest pain or angina
□ High blood pressure
□ Heart murmur
□ Irregular heartbeat
□ Shortness of breath
□ Elevated cholesterol
□ Calf pain when walking
□ Date and location of last EKG

_____

Respiratory
□ Asthma/wheezing
□ Emphysema
□ Chronic cough
□ Pneumonia or bronchitis
□ Tuberculosis
□ Lung cancer

Musculoskeletal
□ Swelling in multiple joints
□ Excessive flexibility
□ Osteoporosis
□ Broken bones
□ Reflex sympathetic dystrophy

Skin
□ Chronic rashes
□ Eczema or psoriasis
□ Skin cancer or melanoma
□ Breast lump or nipple discharge

Gastrointestinal
□ Ulcers or gastritis
□ Reflux
□ Hepatitis or jaundice
□ Gallbladder problems
□ Blood in stool
□ Colon cancer
□ Change in stool shape

Hematological/Immunological
□ Anemia
□ Easy bruising/bleeding
□ Blood transfusion Date:
_____

Neurological
□ Seizures
□ Leg pain or sciatica
□ Arm or leg weakness
□ Sensation loss in arms or legs
□ Loss of bowel or bladder control
□ Loss of memory
□ Stroke Date: _____
□ Depression

Endocrine
□ Diabetes
□ Thyroid Problems
□ Taking hormone replacement
□ Taking prednisone

Genitourinary
□ Bladder infections
□ Blood in urine
□ Difficult with urination
□ Kidney stones
□ Prostate problems
□ Abnormal Pap smear/cancer