Kewanee Physical Therapy & Rehab Specialists

Clinic:	NP	Date:	Time:	Provider :

Adult Registration Form

Last Name :	First Name:	M.I. :
Home Address:	Apt/Lot #:	City :
State :	Zip Code :	Home # :
D.O.B. :	Gender : Female	S. S. # :
Marital Status : Single	Employer :	Work # :
Email :	Seasonal Address : No	Cell # :
How did you hear about us? :	Referring MD :	Phone # :

Extended Information

Emergency Contact:	Relationship:	Phone:
Primary Care Physician :		Phone:
Reason for PT :	2ND Body Part:	New DX:
Injury Type : Other	D.O.I. :	Surgery:
D.M.E. Visit Only :		

Primary Insurance

Company:	Phone:	Extension:
Policyholder:	Phone:	D.O.B. :
Relationship :	Employer:	
Effective Date:	Group #:	I.D./Claim #:

Secondary Insurance

Company:	Phone:	Extension:
Policyholder:	Phone:	D.O.B. :
Relationship :	Employer:	
Effective Date:	Group #:	I.D./Claim #:

Motor Vehicle Accident Insurance

Company :	Adjuster :	Phone :
Policyholder :	Phone :	D.O.B. :
Relationship :	D.O.I. :	Claim #:
Attorney:	Phone :	

Workman's Compensation Insurance

Employer :		
Contact :	Phone :	
Address:		
City :	State :	Zip Code :
Insurance :	Adjuster :	Phone #:
Claim # :		D.O.I. :

Name:_____

Date:_____

Galva • Kewanee • Stark County
Physical Therapy & Rehab Specialists

Please check the following conditions as they apply to you:

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Cardiac Conditions
- ☐ Cardiac Pacemaker
- ☐ Chemical Dependency
- ☐ Circulation Problems
- ☐ Currently Pregnant
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Emphysema/Bronchitis
- ☐ Fractures
- ☐ Gallbladder Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Incontinence
- ☐ Kidney Problems
- ☐ Metal Implants
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Parkinsons
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Strokes
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vision Problems

1. **Are you currently taking any medications?** **Y / N**

   If yes, please list: _____

   _____

2. **Have you had any past surgical procedures?** **Y / N**

   If yes, please list: _____

   _____

3. **Are you currently pregnant?** **Y / N** **Or have you been in the last year?** **Y / N**

4. **Do you smoke?** **Y / N** **Do you drink alcohol?** **Y / N**

5. **Have you received physical therapy previously?** **Y / N**

6. **Is this work related?** **Y / N** **Is this related to an auto accident?** **Y / N**

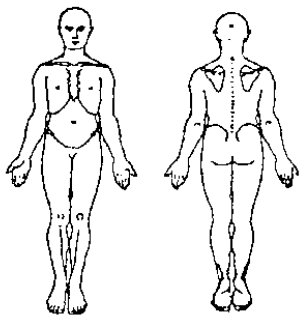
7. **Please describe your injury and location of pain:** _____

_____

_____

_____

Please circle your level of pain:

0 1 2 3 4 5 6 7 8 9 10

0 Being NO pain ***10 go to emergency room***