



Kewanee
Physical
Therapy & Rehab Specialists

Clinic: _____ NP _____ Date: _____ Time: _____ Provider: _____

Minor Registration Form

Patient Last Name: _____ First Name: _____ M.I. : _____
 Home Address: _____ Apt/Lot # : _____ City : _____
 State : _____ Zip Code : _____ Home # : _____
 D.O.B. : _____ Gender: _____ S. S. # : _____
 Marital Status: _____ Employer: _____ Work # : _____
 Email: _____ Seasonal Address: _____ Cell # : _____
 How did you hear about us? : _____ Referring MD: _____ Phone # : _____

Legal Guardian Information (Financial Agreement Responsibility)

Last Name: _____ First Name: _____ M.I. : _____
 Home Address: _____ City: _____ State: _____ Zip Code: _____
 Apt./Lot # : _____ Relationship to patient : _____ Home # : _____
 D.O.B. : _____ Gender: _____ S.S. # : _____
 Marital Status: _____ Employer: _____ Work # : _____
 Email: _____ Seasonal Address : _____ Cell # : _____

Extended Information

Emergency Contact: _____ Relationship: _____ Phone: _____
 Primary Care Physician/Dr : _____ Phone: _____
 Reason for PT: _____ 2ND Body Part: _____ New DX: _____
 Injury Type: _____ 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 #: _____
 Policy/Claim #: _____ D.O.I. : _____



Name: _____

Date: _____

Physical Therapy &
Rehab Specialists

Please check the following conditions as they apply to you:

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

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

