

Patient Registration

Patient Name _____ Weight? _____ lbs. Height? _____ feet _____ inches

Date of injury _____ Is this work related? _____

Are you or is there any chance that you might be pregnant? _____ Yes _____ No

Please check any surgeries that you have had:

<input type="checkbox"/> Cancer Surgery Type _____	<input type="checkbox"/> Fem Pop Bypass Rt. Leg _____ Lt. Leg _____	<input type="checkbox"/> Kidney Removed Rt _____ Lt _____
<input type="checkbox"/> Angioplasty	<input type="checkbox"/> Carotid Endarterectomy Rt _____ Lt _____	<input type="checkbox"/> Kidney Stone Removed
<input type="checkbox"/> Bypass	<input type="checkbox"/> Cataract Removal Right _____ Left _____	<input type="checkbox"/> Prostate removed
<input type="checkbox"/> Stents	<input type="checkbox"/> C-Section	<input type="checkbox"/> T U R P
<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Colon (Bowl Resection)
<input type="checkbox"/> Thyroidectomy	<input type="checkbox"/> Ovaries Removed	
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Hemorrhoidectomy	
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> D & C	
<input type="checkbox"/> Abdominal Aorta Aneurysm Repair	<input type="checkbox"/> Tubal Ligation	
<input type="checkbox"/> Plastic surgery Type _____	<input type="checkbox"/> Breast surgery Type _____	<input type="checkbox"/> hernia repair type _____

Please check any orthopedic surgeries:

<input type="checkbox"/> Shoulder _____ Rt _____ Lt _____ Type of surgery _____	<input type="checkbox"/> Hand/wrist _____ Rt _____ Lt _____ Type of surgery _____
<input type="checkbox"/> Hip _____ Rt _____ Lt _____ Type of surgery _____	<input type="checkbox"/> Foot/ankle _____ Rt _____ Lt _____ Type of surgery _____
<input type="checkbox"/> Knee _____ Rt _____ Lt _____ Type of surgery _____	<input type="checkbox"/> Arm _____ Rt _____ Lt _____ Type of surgery _____
<input type="checkbox"/> Neck/Back _____ Type of surgery _____	<input type="checkbox"/> Leg _____ Rt _____ Lt _____ Type of surgery _____
<input type="checkbox"/> Joint replacement (indicate joint and side of body) _____	

Do you have or have you been treated for any of the following:

<input type="checkbox"/> Skin Diseases	<input type="checkbox"/> Lupus	<input type="checkbox"/> Hepatitis _____ A _____ B _____ C	<input type="checkbox"/> Fractures Type _____
<input type="checkbox"/> Glaucoma Right _____ Left _____	<input type="checkbox"/> A D D	<input type="checkbox"/> Cancer Type _____	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Cataracts Right _____ Left _____	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Gout
<input type="checkbox"/> Asthma	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Paget's
<input type="checkbox"/> C O P D	<input type="checkbox"/> HIV _____ Aids	<input type="checkbox"/> DVT (Blood Clot)	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> C V A (Stroke)	<input type="checkbox"/> Colitis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> High Triglycerides
<input type="checkbox"/> T I A's	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Kidney Stone
<input type="checkbox"/> Parkinson	<input type="checkbox"/> G E R D (Reflux)	<input type="checkbox"/> Stents	<input type="checkbox"/> BPH (Enlarged Prostate)
<input type="checkbox"/> Seizures	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> A-Fib	<input type="checkbox"/> Urinary Tract Infections
<input type="checkbox"/> Anemia	<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Defibrillator	<input type="checkbox"/> Depression

HABITS

Do you use tobacco products? _____ Yes _____ No What? _____ How much/day? _____

Do you consume alcoholic beverages? _____ Yes _____ No How much/day? _____

What medications, prescription and over the counter, are you currently taking? Indicate dosage & direction) _____

ALLERGIES

Do you have any drug allergies? (Name and type of reaction) _____

DO YOU HAVE AN ALLERGY TO LATEX? _____ Yes _____ No

AUTHORIZATION:

By signing this form, I consent to examination and treatment. I also authorize you to obtain information pertaining to my treatment from other physicians. This will include any lab or diagnostic testing needed for treatment purposes.

Signature