NEW CLIENT REGISTRATION FORM
Complete this form and fax to: (904)223-2365
Or scan and email to: jaxpt@fyzical.com

FYZICAL®
Therapy & Balance Centers

Phone: (904) 223-2363 Web: FYZICALcom/Jacksonville

Patient Name: _____ DOB: _____

To ensure you receive a complete and thorough evaluation, provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank you.

Full Name: _____ D.O.B:_____ Age:_____ SSN:_____-_____-_____

Address: Street: _____Apt/Unit #: _____

Address: City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Marital Status (circle one): S M D W

Email address (internal use): _____

Emergency Contact Name:_____ Phone: _____

Employer: _____ Work Phone: _____ Can we leave a message: Y N

Diagnosis/Area to be treated: _____ Date of Injury/Onset of Pain: _____

Primary Physician: _____ How did you hear about FYZICAL? _____

MEDICARE PATIENTS: Have you received Physical Therapy in this year or in the last 90 days? □ No □ Yes, # of visits: _____

Have you received Home Health since your surgery/injury? □ No □ Yes, Name of agency: _____

Phone number of agency: _____ Have you been Discharged? □ No □ Yes, discharge date: _____

IS YOUR CONDITION DUE TO A MOTOR VEHICLE ACCIDENT? □ No □ Yes, Clam #: _____

Insurance company: _____ Adjuster's Name: _____ Number: _____

Name of Attorney Involved: □ No □ Yes, Name: _____ Number: _____ LOP: □ No □ Yes

IS YOUR CONDITION DUE TO A WORKERS COMPENSATION INJURY? □ No □ Yes, Clam #: _____

Insurance company: _____ Adjuster's Name: _____ Number: _____

INSURANCE INFORMATION: Please fill out below as best you can and also bring/email/fax your insurance cards

PRIMARY HEALTH INSURANCE: _____ POLICY #: _____ GROUP #: _____

Phone (Providers): _____ Primary Person Insured □ Self □ Other: _____ DOB: ___/___/_____

SECONDARY HEALTH INSURANCE: _____ POLICY #: _____ GROUP #: _____

Phone (Providers): _____ Primary Person Insured □ Self □ Other: _____ DOB: ___/___/_____

Patient Signature: _____ **Date:** _____

Revised: 1/29/2018

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What is the problem that bring you to therapy? _____

When did your problem start? ____/____/_____ Is this a flare up of a previous injury? □ No □ Yes, Date: ____/____/_____

PAIN: Rate your level of pain: 0 = no pain, 10 = emergency room pain
Today: _____/10 Worst: _____/10 Least: _____/10
Is injury keeping you from doing your normal/recreational activities? □ No □ Yes: _____

Circle your normal (pre-injury) level of activity:
Sedentary Active Athletic

CHANGES IN THE PAST MONTH: Check all that apply.

□ Falls
□ Weight loss/Gain
□ Nausea/Vomiting
□ Fatigue
□ Weakness
□ Fever/chills/sweats
□ Numbness or tingling
□ Depressed/down
□ Difficulty falling asleep

HABITS:
Do you drink caffeinated coffee/beverages? □ No □ Yes: _____ cups/day Do you smoke? □ No □ Yes: _____ packs/day
Do you drink alcohol? □ No □ Yes: _____ days/week, _____ drinks/day

PERSONAL MEDICAL HISTORY:
Have you ever been diagnosed as having any of the following conditions? Please check all that apply.

□ Cancer: _____
□ High blood pressure
□ High cholesterol
□ Pacemaker
□ Heart Condition/Angina
□ Circulation problems
□ Diabetes
□ Other Arthritis conditions
□ Rheumatoid Arthritis
□ Emphysema/Bronchitis
□ Asthma
□ Allergies
□ Unusual reaction to heat/cold
□ Visual/Hearing difficulties
□ Anemia
□ Headaches
□ Depression
□ Stroke
□ Multiple Sclerosis
□ Epilepsy
□ Pregnant or planning to become pregnant
□ Mental Illness
□ Chemical Dependency (i.e., alcoholism)
□ Tuberculosis
□ Hepatitis
□ Kidney Disease
□ Thyroid problems

MAJOR ILLNESS OR SURGERY IN THE LAST YEAR:

Date	Surgery/Hospitalization	Reason

MEDICATION LIST: List any Prescription and over the counter medication you are currently taking (including pills, injections, and/or skin patches): USE ADDITIONAL FORM IF NEEDED

MEDICATION	**DOSAGE**	**FREQUENCY/DAY**	**METHOD** (oral, injection, patch, suppository
1.			
2.			
3.			
4.			
5.			

HEIGHT: _____ **WEIGHT:** _____

Patient Signature: _____ **Date:** _____

Revised: 1/29/2018