Full Potential
PHYSICAL THERAPY

PATIENT REGISTRATION FORM

Personal Information

Name: _____ Patient Birthdate: _____ Male Female

Patient Address: _____ Marital Status: M S W D

Patient City/State/Zip: _____ Spouse's Name: _____

Home Phone: _____

Cell Phone: _____ ***Would you like to receive appt. reminders via text message?*** Yes No

Work Phone: _____ ***Is it OK to call and leave a message at your workplace?*** Yes No

Employer: _____ If Minor, Responsible Party for Payment:

SS Number: _____ _____ _____

Name Relationship

Email Address: _____

By providing your email address, you are consenting to receive emails including, but not limited to, upcoming workshops, health tips, and online newlsetters.

I consent to receive calls and/or texts from Full Potential Physical Therapy for my protected healthcare, and other services, at the phone number(s) above. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

_____ _____

Initial **Date**

In Case of Emergency

Notify _____ Relationship _____

Phone Number (Home) _____ (Cell) _____ (Work) _____

Medical History

Please indicate any of the following conditions you currently have or have had in the past.

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Kidney Problems	☐	☐	Seizures	☐	☐
Cardiac Conditions	☐	☐	Liver Problems	☐	☐	Diabetes	☐	☐
Pacemaker	☐	☐	Cancer	☐	☐	Dizzy Spells/Vertigo	☐	☐
Circulation Problems	☐	☐	Thyroid Problems	☐	☐	Balance Issues/Fall Risk	☐	☐
Arthritis	☐	☐	Strokes	☐	☐	Do you smoke?	☐	☐
Osteoporosis	☐	☐	Headaches	☐	☐	Are you pregnant?	☐	☐
Asthma	☐	☐	Numbness	☐	☐	Height: _____	Weight: _____	

Please list any medications and/or supplements you are currently taking: _____

_____

_____

Please list all surgeries (including metal implants), major illnesses, fractures and the year of their occurrence:

_____

_____

Do you have any allergies? If yes, please list: _____

Primary Care Doctor: _____

Notice of Privacy Practices Acknowledgement

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Full Potential Physical Therapy's Notice of Privacy Practices. By signing below I am "only" giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____ _____

Patient Printed Name Patient's Date of Birth

_____ _____

Signature of Patient or Parent/Legal Guardian Date