



LaFayette Physical Therapy

Registration Information

Patient Information:

Name _____ SS# _____

Date of Birth _____ Age: _____

Mailing Address _____

City _____ Zip Code _____ Tel# _____

E-mail Address _____

Diagnosis: _____ Surgery Date: _____

Physician Information:

Physician's Name _____

Physician's Phone _____ Physician's Fax _____

Date of Next Doctors Appointment: _____

Insured's Information:

Name of Insured/Relation _____ Insured's DOB: _____

Employers Name _____ Tel# _____

Address _____

Primary Insurance/ ID # _____

Secondary Insurance / ID # _____

Medical History: Circle any that apply

Anemia	Cancer	Heart Disease	Hypertension
Lung Disease	Diabetes	Seizures	Metal Implants
Skin Allergies	Osteoporosis	Thyroid Problems	Strokes/head injury
Fractures	Pacemaker	Pregnancy	Hemophilia/bleeding
Incontinence	Asthma	Headaches	Arthritis
Long term prednisone use	Circulation problems	Neuropathy/nerve problems	

Surgical history: _____

List of medications: _____

Fall Risk Assessment: Circle the correct answer

Have you fallen in the last year? Yes No

Did you sustain an injury from the fall? Yes No N/A

Have you had two or more falls in the last year? Yes No N/A

THANK YOU for choosing LaFayette Physical Therapy as your Health Care Provider!

Patient/Responsible Party

Date