

PALM BEACH ORTHOPAEDIC INSTITUTE, P.A.
PT – PATIENT REGISTRATION QUESTIONNAIRE

Score: _____

1. What was the date of your injury or the date your problem began? _____
2. If you have had surgery, what was the date of our procedure? _____
3. Please briefly describe your problem, how you were injured, or reason for attending physical therapy.

4. Have you been to physical therapy for this problem in the past? No Yes
If yes, where and when: _____
5. Have you seen any other health care providers for this problem? No Yes
If yes, who and what specialty were they: _____
6. Have you had any special diagnostic tests for this problem (ie MRI, bone scan, EMG etc)? No Yes
If yes, what type of test and when was it done? _____
7. Please describe what leisure/fitness activities you routinely engage in:

8. What are your personal goals or objectives for attending physical therapy?

9. Please check any areas in which you have previously had, or currently have, medical problems:

<input type="checkbox"/> Allergies	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Cancer	<input type="checkbox"/> Fractures	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Circulation Problem	<input type="checkbox"/> Headaches	<input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Surgery or Joint Replacements
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Visual/Hearing Difficulties

Please list any other pertinent medical conditions or surgeries.

10. Please list medications you are currently taking.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____