PINNACLE THERAPY SERVICES, P.C.
PATIENT REGISTRATION

NAME _____BIRTHDATE_____SS#_____

ADDRESS_____CITY_____STATE_____ZIP_____

TELEPHONE HOME_____WORK_____CELL_____

EMAIL ADDRESS_____

OCCUPATION_____EMPLOYER_____

EMERGENCY CONTACT_____TELEPHONE#_____

REFERRING PHYSICIAN_____TELEPHONE#_____

ADDRESS_____

FAMILY DOCTOR_____TELEPHONE#_____

ADDRESS_____

INSURANCE INFORMATION

CHECK ONE: ☐ MEDICARE ☐ PRIVATE ☐ WORKER'S COMP ☐ AUTO

PRIMARY INSURANCE

INSURANCE COMPANY NAME _____

NAME OF INSURED_____BIRTHDATE_____

IDENTIFICATION/CLAM#_____GROUP#_____

TELEPHONE#_____CONTACT/ADJUSTER_____

DATE OF ACCIDENT/INJURY_____

SECONDARY INSURANCE

INSURANCE COMPANY NAME _____

NAME OF INSURED_____BIRTHDATE_____

IDENTIFICATION/CLAM#_____GROUP#_____

TELEPHONE#_____CONTACT/ADJUSTER_____

CERTIFICATION
I HEREBY CERTIFY THAT THIS INFORMATION GIVEN BY ME IS CORRECT.

_____ _____
PATIENT OR GUARDIAN'S SIGNATURE DATE

Pinnacle Therapy Services
Patient Health Questionnaire

Name _____ Age_____ Birthdate ____/_____/_____

Please tell us when your condition started _____ Did you have surgery? ☐ No ☐ Yes Date _____/_____/_____

Please describe your current complaint or limitation _____

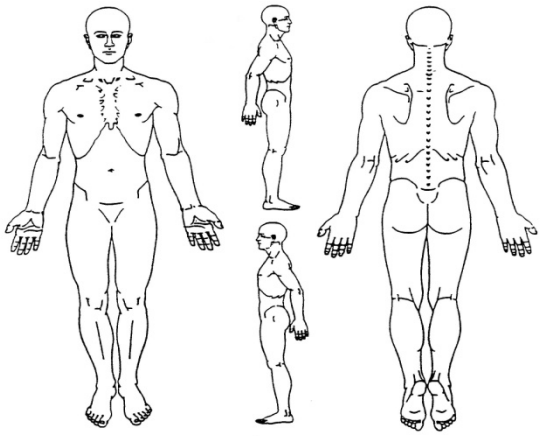
Please describe how your current problem began_____

Please describe the nature of your pain:

☐ Sharp Pain
☐ Dull Ache
☐ Throbbing
☐ Numbness
☐ Shooting
☐ Burning
☐ Tingling

☐ Constant (76-100%)
☐ Frequent (51-75%)
☐ Occasional (26-50%)
☐ Intermittent (25% or less)

Mark on the picture where you have pain or other symptoms



Indicate the intensity of your ***pain at its worst:*** **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)**

Indicate the intensity of your ***pain currently:*** **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)**

Indicate the intensity of your ***pain at its best:*** **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)**

What aggravates your pain: Sitting Standing Walking Stairs Bending Arm use Other_____

Since this condition began your symptoms have: ☐ Decreased ☐ Not changed ☐ Increased

Your symptoms are worse in: ☐ Morning ☐ Afternoon ☐ Evening ☐ Increased during the day ☐ Same all day

In the past have you been treated for the same problem? ☐ Yes ☐ No

If yes, who did you see for that condition: ☐ MD ☐ Physical Therapist ☐ Occupational Therapist ☐ Chiropractor ☐ Other
When and what treatment did you receive? _____

Your occupation_____ Has your work status changed because of this condition? ☐ Yes ☐ No

If you have ever had a listed condition in the past, please check it in the ***past*** column. If you are presently troubled by a particular condition, check in the ***present*** column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding the state of your health.

Past	Present	
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	HIV/AIDS
☐	☐	Cancer: Location _____ Date_____
☐	☐	Systemic Lupus
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Rheumatoid Arthritis
☐	☐	Pregnancy
☐	☐	Arthritis
☐	☐	Other _____

Hospitalization/Surgical Procedures (list if not described elsewhere):_____
_____
_____
_____
_____
_____
_____

Medications:_____
_____
_____
_____

Present: Weight_____ Height_____ft_____in.

_____ _____
Patient Signature **Date**

Documentation of Current Medications

Name:	Date of Birth

Medication Type and Name	Dosage	Frequency	How do you take it?
Prescription	Amount	How often?	By mouth, injection, etc.
Over the counter			
Herbals			
Vitamins, minerals, dietary supplements			

I have completed this form to the best of my knowledge and as accurately as I am able.

Signature	Date: