PATIENT REGISTRATION

Welcome! Thank you for allowing Yoshimoto Physical Therapy to be your physical therapy provider. We greatly appreciate you and your physician's trust in us, and we will make every effort to ensure that your experience is positive and effective.

100% attendance is vital to achieving your goals in physical therapy, so please attend all scheduled appointments.

Name: (Last):_____ (First):_____ (M.I.):_____ Date of Birth:_____
Email:_____
Soc. Sec #:_____-____-_____Home #:_____ Work #:_____ Cell #:_____
Address:_____
City State Zip Code
Occupation:_____ Employer:_____
Address:_____
City State Zip Code

I was referred to Yoshimoto Physical Therapy by:
o My Physician o Nurse Case Mgr/Adjuster o Other: _____
o Friend/Relative (Please write their name if a former patient of us):_____

EMERGENCY CONTACT (Nearest Relative, preferably not living with you):
(Last):_____ (First): _____ (Relationship):_____ (Phone): _____

Patient Medical History

Do you currently have the following:

o Diabetes	o High Blood Pressure	o Psoriasis	o Fatigue
o Asthma	o High Cholesterol	o Headaches	o Pregnant
o Hypertension	o Osteoarthritis	o Nausea/Vomiting	o Surgical Implants
o Pacemaker	o Rheumatoid Arthritis	o Current Infections	o Latex Allergies
o Open Wounds	o Osteoporosis	o Anxiety	o Pain wake you up

o Change in weight past month for no reason o Change in bladder and bowel functions
o Other: _____

Have you ever had the following:
o Heart Disease o Vascular Disease o Stroke / CVA o Seizures
o Chest/Neck/Arm Pain not related to current injury o Cancer/ Tumors o Fainting
o Recent Surgeries: _____
o Other: _____

Please tell us about your current condition
Symptoms that brought you to physical therapy: _____
_____ Date symptoms started: _____

Where did it happen? o Home o Work o Car Accident o Other: _____

Did you have prior physical therapy?
If so, what was your injury, when was it treated, and how many treatments did you receive:
Injury:_____ Date Treated: _____ # of Treatments: _____

Current Medication:_____

Have you ever been hospitalized for this condition? o No o Yes, how long: _____
When is your next MD appointment? _____