Baltimore Holistic Physical Therapy
LIVE LIFE WELL

PATIENT REGISTRATION FORM

NAME _____
Last First M.I.

ADDRESS _____ CITY_____ STATE_____ZIP_____

TELEPHONE (Primary) _____ (Alternate) _____

EMAIL _____ BIRTHDATE _____ MALE/ FEMALE _____

EMERGENCY CONTACT _____
Name Telephone Relationship

PRIMARY CARE PHYSICIAN _____ OFFICE PHONE _____

CURRENT PHYSICIANS AND HEALTH SPECIALISTS- **NAME AND SPECIALTY**:

_____ _____

_____ _____

_____ _____

HAVE YOU HAD PHYSICAL THERAPY BEFORE? _____

SOCIAL HISTORY: ____SMOKES ____ DRINKS ALCOHOL _____ USES RECREATIONAL DRUGS

MARITAL STATUS_____ OCCUPATION_____

ALLERGIES_____

HISTORY OF: CANCER- (type)_____ DIABETES (type)_____

HEPATITIS (type)_____ HIV/AIDS _____

Women: Are you or could you be pregnant? _____

Baltimore Holistic Physical Therapy
LIVE LIFE WELL

PATIENT HISTORY

PATIENT NAME_____ DATE_____

SYSTEMS REVIEW

1. Please **check** all that apply, past or present.
2. Please place a "**C**" next to any current condition.

CARDIOVASCULAR	**NEUROLOGICAL**
___ High blood pressure ___ High cholesterol ___ Chest pain ___ Heart palpitations ___ Heart murmur ___ Heart attack ___ Poor circulation ___ Pacemaker	___ Head Injury ___ Stroke/CVA ___ Sciatica ___ Seizures ___ Shingles ___ Numbness ___ Neuropathy
RESPIRATORY	**MUSCULOSKELETAL**
___ Sinus issues ___ Shortness of breath ___ COVID-19 ___ Asthma ___ Chronic cough ___ Bronchitis ___ Pneumonia ___ Collapsed lung ___ Pleurisy ___ Emphysema ___ Tuberculosis ___COPD	___ Bone fracture ___ Osteoporosis/Osteopenia ___ Fibromyalgia ___ Osteoarthritis ___ Rheumatoid Arthritis ___ Tendinitis ___ Headaches ___ TMJ (jaw) dysfunction ___ Other (describe)
GASTROINTESTINAL	**UROGENITAL AND GYNECOLOGICAL**
___ Difficulty swallowing ___ Indigestion ___ Acid reflux/GERD ___ Bloating ___Ulcer ___Hernia ___ Colitis ___ Irritable bowel syndrome (IBS) ___ Diverticulosis/Diverticulitis ___ Chronic constipation ___ Chronic diarrhea	___ Bladder problems ___ Kidney dysfunction ___ Sexual dysfunction **MEN** ___ Prostate problems **WOMEN** ___ Endometriosis ___ Menstruation problems ___ Menopause

Baltimore Holistic Physical Therapy
LIVE LIFE WELL

PATIENT NAME_____ DATE_____

1. **PLEASE LIST <u>ALL</u> SURGERIES AND PROCEDURES, INCLUDING DATES.**

ORTHOPEDIC

_____

_____

_____

_____

GASTROINTESTINAL

_____

_____

_____

_____

CARDIOVASCULAR

_____

_____

_____

_____

GYNECOLOGICAL

_____

_____

_____

UROGENITAL

_____

_____

_____

COSMETIC

_____

_____

OTHER

_____

_____

2. **PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS.**

_____

_____

_____

_____

_____