Miami Valley Hospital
Premier Health Partners

Registration Form

Today's Date _____ Reason For Being Seen _____

Dr. Convery _____ Dr. Rhodes _____ Date/Onset Of Your Injury: _____

Patient Information:

Last Name	First Name	MI	Date of Birth	SS #

Street Address/P. O. Box	City	County	State	Zip

Sex	Marital Status	Race	Home Phone	Work Phone	Cell Phone
☐M ☐F	☐M ☐S ☐W ☐D				

E-Mail	Employer/Address	Occupation

Primary Care Physician	Name of Custodial Parent	Relationship to Responsible Party
		☐Self ☐Spouse ☐Child ☐Other _____

Cardholder Information: (if different from above)

Last Name	First Name	MI	Date of Birth	SS #

Street Address/P. O. Box	City	State	Zip

Sex	Home Phone	Work Phone	Cell Phone
☐M ☐F			

E-Mail	Employer	Occupation

Employer Address	City, State	Zip Code

Emergency Contact:

Name	Relationship	Phone	Place of Employment	Work Phone

Insurance/Policy Holder Information: (Please present insurance cards to receptionist)

Primary Insurance	Policy Holder	Sex	Policy Holder Birthdate	Policy Holder SS #
		☐M ☐F		

Employer	Work Phone	Patient Relationship to Policy Holder
		☐Self ☐Spouse ☐Child ☐Other _____

Secondary Insurance:

Secondary Insurance	Policy Holder	Sex	Policy Holder Birthdate	Policy Holder SS #
		☐M ☐F		

Employer	Work Phone	Patient Relationship to Policy Holder
		☐Self ☐Spouse ☐Child ☐Other _____

Authorization For Treatment:

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of x-rays and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of the Miami Valley Hospital Sports Medicine Center. I realize that if a medical procedure or surgery is required, I will be given additional information.

_____ _____ _____

(Signature of Patient or Authorized Representative) (Witness) (Date)

Miami Valley Hospital
Premier Health Partners

Sports Medicine
Physical Therapy
Occupational Therapy

Medical Questionnaire

Date: _____

Name: _____ Age: _____ DOB: _____ ☐ Male ☐ Female

Home Phone: (____) _____Work Phone: (____) _____ Email address: _____

Family Physician: _____ Phone: (____) _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: (____) _____

Work History:

If student, what school do you attend? _____

Occupation: _____ Are you currently working? ☐ Yes ☐ No ☐ Full Time ☐ Part Time

Type of activity on this job: (Check all that apply)

☐ Sitting ☐ Standing ☐ Office Work ☐ Manual Labor

☐ Light Activity ☐ Moderate activity ☐ Heavy Labor

Do you participate in any recreational activities/Hobbies? ☐ Yes ☐ No

Describe: _____

Referral Information:

Reason for your referral to Sports Medicine/Therapy: _____

What caused your injury? _____

Date of onset of symptoms/injury: _____ Date of Surgery: _____

What activities do you find the most difficult to perform since your injury/surgery? _____

_____

Are you Right or Left handed? _____

Safety Assessment:

Have you had any falls within the past few months? ☐ Yes ☐ No

Have you had any problems with confusion, disorientation, impulsiveness, or restlessness? ☐ Yes ☐ No

Do you have any problems with mobility, balance, vertigo, dizziness, neuropathy, or have difficulty rising from flat surfaces? ☐ Yes ☐ No

Do you use any assistive devices (walker, cane, wheelchair)? ☐ Yes ☐ No

Do you have any altered bowel or bladder habits (urgency, frequency, incontinence)? ☐ Yes ☐ No

Are you on any of the following types of medication? Hypnotics, anesthetic/sedatives, hypertensives, laxatives, diuretics, benzodiazepines, anti-epileptics? ☐ Yes ☐ No

Do you have any sensory deficits/losses (vision, hearing, neuropathies)? ☐ Yes ☐ No

Is English your second language? ☐ Yes ☐ No

Are you over 65? ☐ Yes ☐ No

Please list any previous injuries (severe sprains, fractures, etc.) _____

_____

What is your preferred learning style? ☐ Verbal ☐ Written ☐ Demonstration ☐ Other

If other, explain _____

Last grade level completed: _____

Nutritional Screen:

In the past 6 months, have you had any problems with the following? (check all that apply)

- ☐ Loss of Appetite
- ☐ Nausea/Vomiting
- ☐ Problems with eating
- ☐ Special Diet
- ☐ No problems
- ☐ Recent weight loss _____ lbs / gain _____ lbs
- ☐ Diet medications
- ☐ Pregnant/breast feeding
- ☐ Skin problems

Special Barriers:

Do you have any of the following barriers or special considerations which may affect your education or treatment at this time?

☐ Cultural/Values/Religious beliefs ☐ Language/communication barriers ☐ Medical conditions

☐ Emotional/cognitive barriers ☐ Financial concerns ☐ Other ☐ No problems

Extra Precautions:

Do you have any of the following? (check all that apply)

☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Limited range of motion

☐ Metal implants ☐ Pacemaker ☐ Heart disease ☐ Recent fracture

☐ Skin condition ☐ Seizure disorder ☐ Fall risk

Current Medications:

Name of Medication	Reason for Taking	Effectiveness

Name _____ DOB: _____

Self/Family History:

Please check any illness or condition that you or your family members have had:

Illness/Condition	Myself	Family Member	Illness/Condition	Myself	Family Member
Arthritis	☐	☐	Asthma	☐	☐
Cancer: _____	☐	☐	Chemical Dependency	☐	☐
Depression	☐	☐	Diabetes	☐	☐
Epilepsy	☐	☐	Emphysema	☐	☐
Heart attack	☐	☐	Hepatitis	☐	☐
High blood pressure	☐	☐	Kidney disease	☐	☐
Multiple sclerosis	☐	☐	Stroke	☐	☐
Thyroid problems	☐	☐	Tuberculosis	☐	☐
Other: _____	☐	☐	Other: _____	☐	☐

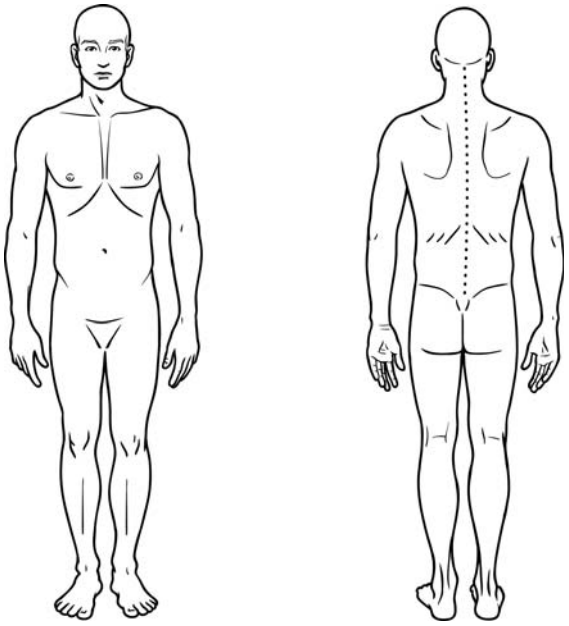
Do you have any allergies or sensitivities? ☐ Yes ☐ No

If yes, please explain _____

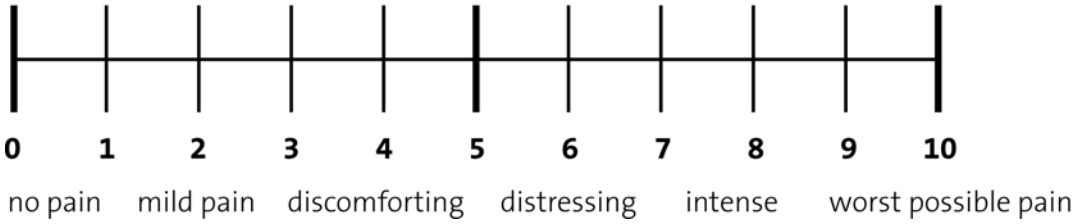
What types of reactions do you have to these allergies? _____

_____

Pain Information: Indicate your symptom(s)/area(s) of pain on the body diagrams below.



Rate your current pain level on the scale below: *(Please circle a number)*



When did your pain start? _____ Where is your pain located? _____

Please describe your pain: (check all that apply)

☐ Sharp ☐ Dull ☐ Aching ☐ Cramping ☐ Burning ☐ Throbbing

☐ Other: _____

Is your pain: ☐ Brief ☐ Intermittent ☐ Constant

What increases your pain? _____

What decreases your pain? _____

What do you expect your pain level to be reduced to upon completion of physical therapy? _____ (1-10)

SUMBIT BY EMAIL HERE