CENTER FOR MUSCLE & JOINT THERAPY, INC. ***REGISTRATION (pg 1)***

Patient Name: (First, MI, Last)		Date of Birth:
Address: (Street)		
Address: (City, State, ZIP)		
Soc. Security #: ***Required for Work Comp & Military Ins***		☐ Male ☐ Female ☐ Other ______________
Email:		
Phone Numbers: May we leave a message on this phone:	HOME: ☐ Yes ☐ No MOBILE: ☐ Yes ☐ No WORK: ☐ Yes ☐ No	
Employer:		
Student:	☐ Yes ☐ No School:	
Date of Injury or when symptoms began:		
Referring Physician:		
Primary Care Physician:		
Is condition related to:	☐ Employment ☐ Auto Accident ☐ Other Accident ☐ No	
Claim #:		
Ins Company Name:		
Contact Name:		
Phone Number:		
Responsible Party: ***(if different than Patient)***		
Relationship to Patient:		*Date of Birth:*
Address: (Street)		
Address: (City, State, ZIP)		
Phone Number:		
How Did You Hear About Us?	☐ Previous Patient ☐ Physician Referral ☐ Friend Referral	
	☐ Television Ad ☐ Yellow Pages ☐ Website (www.cmjt.net)	
	☐ Facebook ☐ Twitter ☐ Other	

CENTER FOR MUSCLE & JOINT THERAPY, INC. ***REGISTRATION (pg 2)***

Health History

1. Have you had physical therapy elsewhere in this calendar year? ☐YES ☐NO

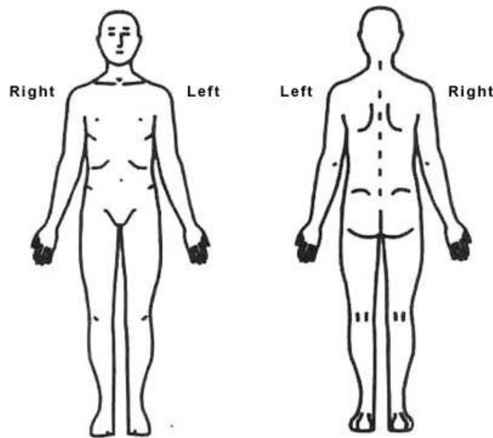
2. Are you presently under any medical treatment, other than physical therapy? ☐YES ☐NO
   If yes, explain:____

3. Do you now or have you ever had an allergy to any of the following?
   I Do Not Have Any Allergies: ☐

   ☐Cold Application ☐Heat Application
   ☐Petroleum Products ☐Adhesive Tape
   ☐Latex/Rubber
   ☐Drugs/Medications
   Please list: ____
   ____

4. Do you have pain ***TODAY***?

<u>Where is your PAIN? (Please circle)</u>



Emergency Contact Information

Name:____

Phone #: __________________________ Relation to patient: ________________________________

Patient Name: ____