Mill Valley
247 Shoreline Highway, Suite A9
Mill Valley, CA 94941
PHONE 415.381.8707
FAX 415.634.3066
www.ptrenew.com

San Francisco
659 Commercial Street, Suite 101
San Francisco, CA 94111
PHONE 415.904.8707
FAX 415.276.6024

NEW PATIENT REGISTRATION

☐ PHYSICAL THERAPY ☐ ORTHOPEDIC SCREENING ☐ POST REHAB GYM PROGRAM TODAY'S DATE: ______________________

LAST NAME ______ FIRST NAME ______ DATE OF BIRTH ______ GENDER: ☐ M ☐ F

STREET ADDRESS ______ CITY ______ STATE ______ ZIP ______

HOME PHONE ______ MOBILE PHONE ______ EMAIL ADDRESS ______

EMPLOYER ______ WORK PHONE ______ OCCUPATION ______

APPOINTMENT REMINDERS: ☐ VOICE ☐ TEXT ☐ EMAIL ☐ NONE

INSURANCE INFORMATION

☐ AUTO ACCIDENT ☐ SELF PAY ☐ INSURANCE

PRIMARY INSURANCE

INSURANCE COMPANY ______

MEMBER ID ______ GROUP NUMBER ______

INSURED NAME (IF OTHER THAN PATIENT) ______ DATE OF BIRTH ______

RELATIONSHIP TO INSURED: ☐ SELF ☐ SPOUSE/PARTNER ☐ PARENT/GUARDIAN

SECONDARY INSURANCE COMPANY

INSURANCE COMPANY ______

MEMBER ID ______ GROUP NUMBER ______

REFERRAL

REFERRING PHYSICIAN ______

PHONE ______ FAX ______

PRIMARY CARE PHYSICIAN ______

HOW DID YOU HEAR ABOUT US?

☐ PHYSICIAN ☐ FRIEND/RELATIVE ☐ INTERNET ☐ OTHER

REFERRAL NAME OR WEBSITE URL ______

EMERGENCY CONTACT INFORMATION

NAME ______

STREET ______ CITY ______ STATE ______ ZIP ______

PHONE ______ RELATIONSHIP ______

SIGNATURE ______ DATE ______

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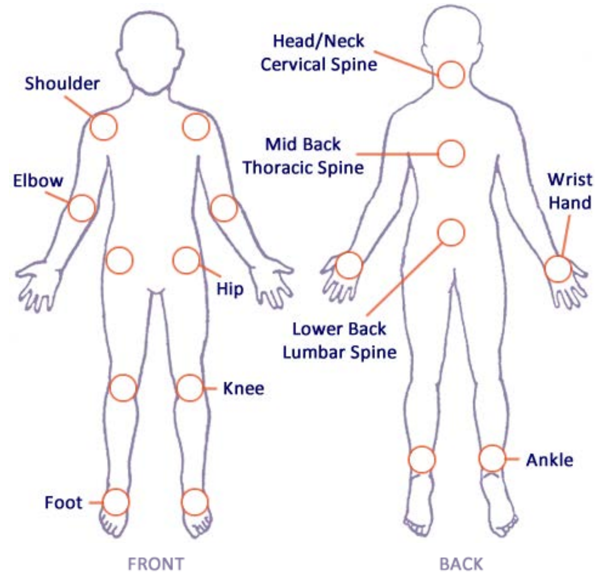
PRE-EXAM QUESTIONNAIRE

In order to evaluate your condition fully, please be as accurate as possible. Thank you.



1. What is your age? ___________

2. What is your gender? ☐ MALE ☐ FEMALE

3. What is your occupation? _______________________________

Are you currently working? ☐ YES ☐ NO

4. Have you had physical therapy before? ☐ YES ☐ NO

5. Where is your pain or problem? _________________________

(Please indicate the areas where you are experiencing pain on the diagram.)

6. What caused your pain or problem? ______________________

7. Approximately when did it start? _________________________

8. Is your pain getting: ☐ BETTER ☐ SAME ☐ WORSE

9. Have you ever had this pain or problem before? ☐ YES ☐ NO

If yes, when? ____

10. Is your pain constant (never goes away)? ☐ YES ☐ NO

11. Indicate your worst pain level in the past couple of days: NONE ☐0 MILD ☐1 ☐2 ☐3 MODERATE ☐4 ☐5 ☐6 ☐7 ☐8 SEVERE ☐9 ☐10

12. Are you taking any medication for this pain or problem? ☐ YES ☐ NO

If yes, please list:____

13. Are you **UNABLE** to perform any functions or activities of daily living as a result of your pain/problem? ☐ YES ☐ NO

If yes, please list which ones:____

14. List all past surgeries with dates: ____

____

15. List all medical conditions you have (or were told you have). ___________________________________

____

____

PATIENT NAME

____ ______________________

SIGNATURE DATE

____

PHYSICAL THERAPIST INITIALS

Alternatively: Save the completed form to your computer, compose a new message in your e-mail client, attach the saved form and send to: info@ptrenew.com