THE PERFORMANCE REFINERY
Functional Movement + Body Mechanics Specialists

Registration

1. Patient Information

Last Name | First Name | Middle Name or Initial

What you prefer to be called

Gender
○ Transgender ○ Female ○ Male

Birthdate: mm/dd/yyyy | Age

Mailing Address: | City

State | ZipCode | Home Phone:

Work Phone: | Cell Phone: | E-mail Address:

Whom may we thank for referring you to our office?

Employer's Name/Company Name

What is your Occupation?

Status:
○ Life Partner ○ Married ○ Single ○ Minor

Spouse's Name

Do you have children?
○ No ○ Yes

3. ACCOUNT INFORMATION

Person ultimately responsible for account | What is your relation to patient

Billing Address

City | State | ZipCode

Please click to acknowledge you agree with the above statement.
○ I do not Agree ○ Agree

What is your preferred payment method?
☐ Credit Card ☐ Check ☐ Cash

4. IN EVENT OF AN EMERGENCY

Whom should we contact? | Relation to Patient

Home Phone # | Work Phone # | Cell Phone #

Who is your Medical Doctor? | MD's/Doctors Phone #

Page 2 - Physiotherapy Patient - Medical History

5. REASON FOR VISIT

Reason for today's visit:
○ Wellness ○ Chronic pain ○ Old injury ○ New injury ○ Emergency

Are you in pain?
○ Yes ○ No

Rate your pain: 10 = severe pain
○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Did your injury occur during:
☐ Routine/Household activity ☐ Work ☐ Sports/play ☐ Auto Accident

Date your condition/accident occured? | Where did your injury occur?

Please explain what happened:

Is your condition getting worse?

☐ Yes ☐ No ☐ Constant ☐ Comes and goes.

Is your condition interfering with your:

☐ Work ☐ Sleep ☐ Daily routine?

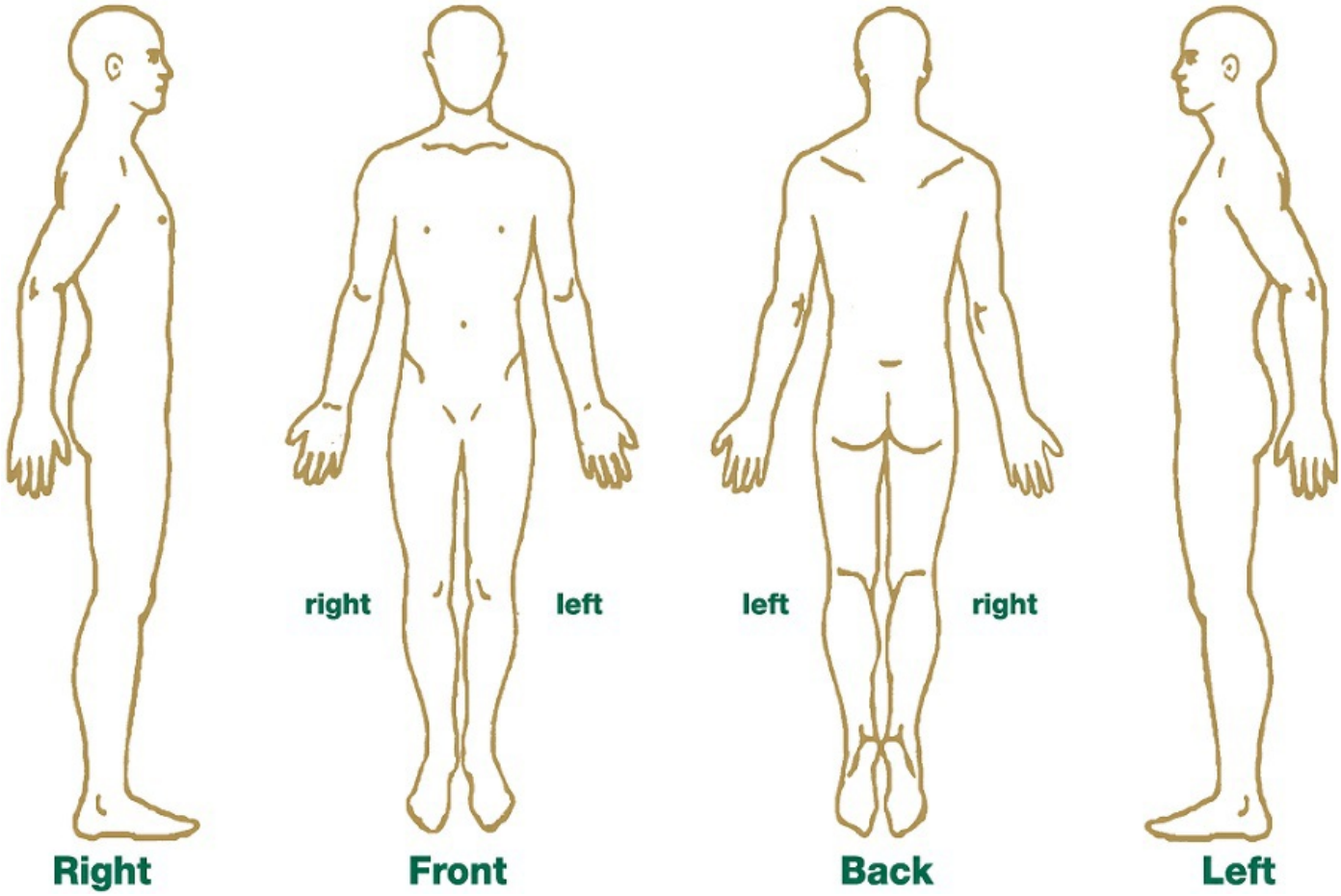
How has your condition interfered?

Has this or something similar happened in the past?

○ Yes ○ No

Explain:

Mark all affected areas.



Have you been treated by a Medical Physician/Doctor for this condition?

○ Yes ○ No

Medical Physician/Doctors Contact Info

Have you ever been treated by a Physical Therapist or Chiropractor?

○ Yes ○ No

Previous Physical Therapist/Chiropractors Contact Information

Are you an Equestrian Rider

○ Yes ○ No

What discipline do you ride

How many horses per day do you currently work

Are there any particular riding movements that you find difficult or cause you pain

6. MEDICAL INFORMATION

Are you taking any of the following medications?

☐ Nerve pills ☐ Pain killer(including aspirin) ☐ Muscle relaxers ☐ Blood Thinners ☐ Insulin ☐ Stimulants ☐ Other(s)

Please list any other medications you are taking? (include over the counter)

Do you have or have you had any of the following diseases, medical conditions or procedures?

☐ Arthritis ☐ Artificial Bones/Joints/Implants ☐ Lower Back Problems ☐ Chemotherapy ☐ Difficulty Breathing ☐ Tuberculosis ☐ Emphysema / Asthma
☐ Sinus Problems ☐ Fainting/Seizures/Epilepsy ☐ Ulcers / Colitisemia ☐ Kidney Problems ☐ Severe / Frequent Headaches ☐ Rheumatic Fever
☐ Psychiatric Problems ☐ High/Low Blood Pressure ☐ Anemia / Diabetes ☐ Glaucoma ☐ Frequent Neck Pain ☐ Cancer ☐ Shingles
☐ HIV+ / AIDS / ARC ☐ Heart Attack / Stroke ☐ Heart Surg./Pacemaker ☐ Congenital Heart Defect ☐ Mitral Valve Prolapse ☐ Artificial Valves
☐ Alcohol / Drug Abuse ☐ Venereal Disease ☐ Hepatitis

Please list any surgeries with dates and/or any other serious medical condition(s) not listed above:

List any past serious accidents with dates:

Please list anything that you may be allergic to:

Family Health History:

Do you take Supplements or Vitamins?

○ Yes ○ No

Do you exercise?

○ No ○ Yes

Hours per week

Do you smoke?

○ Yes ○ No

How much do you smoke?

How long have you smoked?

Are you wearing:

☐ Shoe lifts ☐ Inner soles ☐ Arch supports

Are you dieting:

○ No ○ Yes

For women: Are you taking Birth Control pills?

○ No ○ Yes

Date Since Starting Diet

Are you taking hormonal replacement

○ No ○ Yes

Are you nursing?

○ No ○ Yes

Are you Pregnant?

○ Yes ○ No

If Yes, how long?

I acknowledge that by typing my full legal name below, this constitutes my digital signature.

○ I acknowledge my digital signature below.

Print your Name to sign: