



Chris Johnson PT, PLLC
115 West 27th St - 11th Floor
New York, NY 10001
347.433.6789

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www.chrisjohnsonpt.com

REGISTRATION:

Patient Information

First Name: _____ Middle Initial: _____ Last Name: _____

Home Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security: _____ Sex: Male () Female () Date of Birth: _____

Referring Doctor: _____ Diagnosis: _____

Insurance Information

Primary Insurance Company Name: _____

Name of Insurance Policy Holder: _____

Insured's Social Security Number: _____ Insured's Date of Birth: _____

Insurance Policy Number: _____ Insurance Company Phone: _____

Insured's Employer: _____ Employer Address: _____

Secondary Insurance Company Name (If applicable): _____

Insurance Co. State & Zip: _____ Insured's Policy Number: _____



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MEDICAL HISTORY:

Name: _____ Date: _____ DOB: _____

Age: _____ Height: _____ Weight: _____ Dominant Hand: _____

Leisure Activities & Exercise Routines: _____

Are you on any work restrictions from your physician?: _____

Do you smoke? Yes No

Do you have a pacemaker? Yes No

No Latex Sensitivity? Yes No

Allergies?: _____

Women: Are you currently pregnant or you think you might be pregnant? Yes No

Have you recently experienced any of the following (please circle):

Fatigue	Numbness of Tingling	Constipation
Fever/Chills/Sweats	Muscle Weakness	Diarrhea
Nausea/vomiting	Dizziness/Lightheadedness	Short Breath
Weight loss/gain	Heartburn/Indigestion	Fainting
Balance difficulties	Difficulty swallowing	Cough
Falls	Change in bowel/bladder	Headaches

Have you ever been diagnosed with any of the following (please circle):

Cancer	Depression	Thyroid
Heart problems	Lung problems	Diabetes
Chest pain	Tuberculosis	Osteoporosis
High blood pressure	Asthma	Multiple Sclerosis
Circulation problems	Rheumatism Epilepsy	Blood clots
Skin Infection	Kidney problem	Stroke
Bladder/Urinary Infection	Ulcers	Anemia
Eye irritation/infection	Liver problems	Chemical dependency
STD/HIV	Hepatitis	

Patient Name: _____ DOB: _____

Has anyone in your immediate family ever been diagnosed with any of the following (please circle):

Cancer	Diabetes	Tuberculosis
Heart problems	Stroke	Thyroid
problems		
High blood pressure	Depression	Blood clots

Please list any medications you are currently taking:

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Please list any past surgeries you have had to include the type of procedure, date it was performed, and physician who performed it:

1. _____
2. _____
3. _____
4. _____
5. _____

How long ago did your symptoms start? _____

What caused your symptoms? _____

Have you received any diagnostic tests?: Xrays MRI Ultrasound CT Scan Bone Scan

Pain Rating (with 0 being no pain and 10 being worst imaginable pain):

Current	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10

Nature of Symptoms: Shooting Burning Aching Numbness Tingling

Patient Name: _____ DOB: _____

Are your symptoms currently: Better Worse Staying the same

When are your symptoms best?: Morning Afternoon Evening Night After Exercise

When are your symptoms worst?: Morning Afternoon Evening Night After Exercise

Aggravating Factors: _____

Relieving Factors: _____

Summary of Chief Complaint: _____



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ATTENDANCE POLICY:

Chris Johnson PT is determined to provide each patient with unmatched physical therapy care while attempting to accommodate your schedule to the best of our abilities. We will provide you with reserved time slots to minimize waiting times and assure continuity of your treatment. Consistent attendance and adhering to the treatment plan is critical to your recovery.

Cancellations along with no-shows decrease our ability to accommodate scheduling needs. We ask for your full cooperation with the following policies:

*If you are unable to keep a scheduled appointment, we request that you notify our office 24 hours in advance of your scheduled appointment time. If someone is not available to take your call, please leave a message on our answering system.

*All cancellations and no shows will be documented and reported to your physician.

*If you have 2 cancellations or no-shows, you will be referred back to your physician before scheduling another appointment or you will be discharged from our care and this will be reported to your physician.

***If you fail to honor a scheduled appointment, either by later cancellation or no show, you will be charged \$75.00, due at the beginning of your next scheduled appointment.**

This policy is necessary for the benefit of all patients, so that high quality care and service can be rendered.

Chris Johnson PT staff and patients appreciate your cooperation and strict adherence with this policy.

Patient Signature: _____ Date: _____ DOB: _____

