



**Coppersmith  
Orthopedic & Sports Physical Therapy**

5025 25th Ave NE, # 201, Seattle, WA 98105 206-524-6702

**Patient Registration - 1**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Address 2 \_\_\_\_\_ E-mail \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ SSN \_\_\_\_\_ Gender \_\_\_\_\_ Marital Status \_\_\_\_\_

**Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**Employer:**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Problem:**

Description \_\_\_\_\_  
 Date of Injury \_\_\_\_\_ Last Physician Visit \_\_\_\_\_  
 Referred By \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
 Motor Vehicle Accident? \_\_\_\_\_ Date occurred \_\_\_\_\_

**Primary Insurance:**

Insurance \_\_\_\_\_  
 ID # \_\_\_\_\_  
 Group # \_\_\_\_\_

**Subscriber:**

Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

**Secondary Insurance:**

Insurance \_\_\_\_\_  
 ID # \_\_\_\_\_  
 Group # \_\_\_\_\_

**Subscriber:**

Name \_\_\_\_\_  
 Relationship \_\_\_\_\_  
 Date of Birth \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

*I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed.*

*I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 206-524-6702, requesting one at this office, or on the web at [www.coppersmithpt.com](http://www.coppersmithpt.com).*

Signature \_\_\_\_\_ Date \_\_\_\_\_

As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

*I AUTHORIZE COPPERSMITH ORTHO & SPORTS PHYSICAL THERAPY TO RELEASE ANY INFORMATION ACQUIRED IN THE COURSE OF MY OR MY DEPENDENT'S EXAMINATION OR TREATMENT ONLY TO THE AUTHORIZED INSURANCE CARRIER, LEGAL COUNSEL, OR REQUESTING PHYSICIAN.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

**ASSIGNMENT OF INSURANCE BENEFITS**

*I AUTHORIZE THE PAYMENT OF MEDICAL BENEFITS TO BE MADE TO COPPERSMITH ORTHO & SPORTS PHYSICAL THERAPY AND/OR THE PHYSICAL THERAPISTS OF COSPT FOR SERVICES RENDERED TO MYSELF OR MY DEPENDENTS COVERED UNDER MY INSURANCE. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF ANY AND ALL MEDICAL BILLS INCURRED.*

Signature \_\_\_\_\_ Date \_\_\_\_\_



To ensure you receive a complete and thorough evaluation, please provide us with the important background information requested on this form. If you do not understand a question, please leave it blank and your therapist will assist you. Thank you!

Allergies: Please list any medications you are allergic to: \_\_\_\_\_

Please list any other allergies: \_\_\_\_\_

Are you latex sensitive?  Yes  No

Please check any of the following whose care you are under:

- Physician (MD, DO)       Podiatrist (DPM)       Psychiatrist/Psychologist  
 Physical Therapist       Chiropractor (DC)       Other: \_\_\_\_\_

If you have seen any of the above professionals during the last 3 months, please describe the reason (illness, medical, routine, etc) \_\_\_\_\_

Do you have an Advanced Directive?  Yes  No \_\_\_\_\_

Have you ever been diagnosed as having any of the following conditions?

- |   |  |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer               | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid Condition      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No Other Arthritic Condition |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure  | <input type="checkbox"/> Yes <input type="checkbox"/> No Depression                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Circulation Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma               | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema/Bronchitis | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chemical Dependency  | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Disease            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems     | <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes             | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis   | <input type="checkbox"/> Yes <input type="checkbox"/> No Currently pregnant        |

Have you recently noticed?

- |  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Weight loss/gain          | <input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Nausea/Vomiting           | <input type="checkbox"/> Yes <input type="checkbox"/> No Weakness            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Dizziness/Lightheadedness | <input type="checkbox"/> Yes <input type="checkbox"/> No Fever/Chills/Sweats |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Numbness or tingling      |  |



Please place an "X" on each line to indicate the intensity of your pain or other symptoms:

**Current Pain:** Mark to indicate your pain level **at the present time.**

\_\_\_\_\_

(No Pain) (Worst Pain Ever)

**Least Pain:** Mark to indicate the least amount of pain you have had **in the last week.**

\_\_\_\_\_

(No Pain) (Worst Pain Ever)

**Worst Pain:** Mark to indicate the worst amount of pain you have had **in the last week.**

\_\_\_\_\_

(No Pain) (Worst Pain Ever)

Please list any prescription and/or over the counter medications you are currently taking:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please describe any surgeries or significant injuries for which you have treated:

_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____
_____	Date: _____	_____	Date: _____

Briefly state your personal goals for your Physical Therapy treatment:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_