Patient Registration Form

INVICTUS
SPORTS MEDICINE

First Name: ________________ Last Name: __________________

Date of Birth: ____/____/____

Address: ______________________________City: ________________ Zip Code: _________

Home Phone: _______________ Cell Phone: ______________ Email: ______________________

Emergency Contact Info: (Name): __________________________ (Phone): ___________________

(Relationship):_____________________

How did you hear about Invictus Sports Medicine? □Physician □Friend/Relative □Website
□Insurance Company □Facebook □School □Other:_________________________

Have you had Physical or Occupational Therapy elsewhere this year? □ Yes □ No
Is your injury work related? □ Yes □ No
Have you been injured as a result of a fall in the past year? □ Yes □ No
Have you had 2 or more falls in the last year? □ Yes □ No
Are you currently receiving home health care? □ Yes □ No

Medical History (Please circle **Yes** or **No**)

Allergies	Yes	No	High Cholesterol	Yes	No
Anemia	Yes	No	High/Low Blood Pressure	Yes	No
Anxiety	Yes	No	HIV/AIDS	Yes	No
Asthma	Yes	No	Incontinence	Yes	No
Auto Immune Disorder	Yes	No	Kidney Problems	Yes	No
Cancer	Yes	No	Metal Implants	Yes	No
Cardiac Conditions	Yes	No	MRSA	Yes	No
Cardiac Pacemaker	Yes	No	Multiple Sclerosis	Yes	No
Chemical Dependency	Yes	No	Muscular Disease	Yes	No
Circulation Problems	Yes	No	Osteoporosis	Yes	No
Currently Pregnant	Yes	No	Parkinson's	Yes	No
Depression	Yes	No	Rheumatoid Arthritis	Yes	No
Diabetes	Yes	No	Seizures	Yes	No
Dizziness	Yes	No	Smoking	Yes	No
Emphysema/Bronchitis	Yes	No	Speech Problems	Yes	No
Fibromyalgia	Yes	No	Stroke/TIA	Yes	No
Fractures	Yes	No	Thyroid Disease	Yes	No
Gallbladder Problems	Yes	No	Tuberculosis	Yes	No
Headaches	Yes	No	Vertigo	Yes	No
Hearing Impairment	Yes	No	Vision Problems	Yes	No
Hepatitis	Yes	No			

Please describe any other conditions not listed:____

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____

List any allergies (if applicable): ____
____

Surgical History Please list surgeries (if applicable)

Body Region	Surgery Type	Month/Year

Current Medications Please list medication (if applicable) or provide a medication list.

Name of Medication	Dosage	Frequency	Reason for Taking

Note: Invictus Sports Medicine requires a 24-hour notice for cancellation. Failure to comply may result in a **$35** cancellation/no show fee. Please initial indicating you understand our policy. _________ **(initial here)**

Patient Signature/Authorized Representative: ____________________________________
Date: ____/____/______

Patient Printed Name/Authorized Representative: ________________________________
Relationship: ________________________