# ETI Wound Healing Center

## Registration

Greg Eck, PT, CWS, FACCWS

## Patient Information

Date ______________________________

Name _____________________________

Social Security # _____-___-_______

Address ___________________________

City ______________________________

State___________________ Zip________

Birthdate __-__-____ Sex M F

__Married __Widowed __Single __Minor

__Separated __Divorced __ Partnered

Spouse Name _____________________

Family Doctor ______________________

Clinic Name _______________________

Referred By?________________________

## Insurance Information

Who is responsible for this account?

___________________________________

Relationship to Patient ________________

~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~

Insurance Co ________________________

Group # __________ Policy #__________

Subscribers Name ____________________

Birthdate__-__-____ SS# ___-__-____

Is Patient covered by additional insurance?
___ Yes ___No

Insurance Co ________________________

Group # __________ Policy #__________

## Phone Numbers

**Home Phone (_____) _____-______**

**Cell Phone (_____) _____-______**

**IN CASE OF EMERGENCY, CONTACT?**

**Name ____________________ Relationship___________**

**Home Phone (_____) _____-______**

**Work Phone (_____) _____-______**

## Accident Information

**Is condition due to an accident? ____ Yes ____ No**

**Type of Accident: ___Auto ___Work ___ Home ___ Other**

**To whom have you made a report of your accident?**

**____Auto Insurance _____Employer _____Workers Comp**

**_____Other ______________________________________**

**Attorney Name (if applicable) ___________________________**

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## Health History

## Patient Condition

**Reason for visit?** ____________________________________________________________

**When did symptoms appear?** _________________________

**Pain Scale: Rate from 0-10 ( 0 = No Pain ) ( 10 = Extreme Pain )** **At rest** ______ **With Activity** ______

**Does your pain interfere with any of the following?** ____ Work ____Sleep ____Daily Routine ____Recreation

**Activities or movements that are painful to perform?** ____Sitting ____Standing ____Walking ____Bending ____Lying Down

## Have you been diagnosed or have a history of the following:

—— **Diabetes**

—— **Hearing/Vision Problems**

—— **High Blood Pressure**

—— **Stroke**

—— **Pacemaker**

—— **Chemical Dependency**

—— **Metallic Implants**

—— **Arthritis**

—— **Rheumatoid Arthritis**

—— **Falls**

—— **Multiple Sclerosis**

—— **Tuberculosis**

—— **Active Respiratory Issues**

—— **Circulation Disorders**

—— **Osteoporosis**

—— **Seizures**

—— **Cancer/Radiation**

—— **Heart Problems**_____________

—— **AIDS/HIV**

—— **Mental Illness**

—— **Depression**

—— **Hepatitis**

—— **Anemia**

—— **Allergies or Allergic Reactions**

**Explain** ———————————

______________________________

______________________________

## Habits

_______ **Smoking Packs/Day**

_______ **Alcohol Drinks/Week**

______ **Coffee/Caffeine Cups/Daily**

______ **High Stress Reason**

## Medications

Please list all medications related to current problem (including prescription, vitamins, herbs and minerals) :

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

## Past Injury/Surgery

Please list all related past injuries/surgeries (include dates) :

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________