



Client Registration Form

Name: _____ S.S.# _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Sex: _____ Date of Birth: (m/d/y) _____

What company sent you? _____

Department: _____ Job Hired For: _____

Address: _____ Phone: _____

Contact Person: _____ Work Comp Ins Carrier: _____

HISTORY

NOT TO BE RELEASED TO EMPLOYER

Allergies: _____

Current Medication: (including prescriptions, over the counter medicine, vitamins, herbs): _____

Smoker: (packs per day): _____ Nonsmoker/Quit: _____

Exercise program: Yes No Times per week: _____

Nutrition: Significant weight change? Yes No

Chewing or swallowing problems? Yes No

Describe your diet: (Check One) Excellent Good Fair Poor

Functional: Ability to perform daily activities, (speech, memory, communication, hygiene, & dressing)

Excellent Good Fair Poor

Educational Needs/Preferences: (Please check preference for learning)

Reading Listening Demonstration Interpretation

Rate Your Pain Level: (circle one number)

0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Moderate Severe Emergency Level

Personal Physician: _____

Medical History: (M) Mother (F) Father (S) Self Cancer Sugar Diabetes

Heart Problems Other _____

Job History: _____ Known Hazardous Exposures: _____

Previous Injuries: _____

Immunizations: Tetanus _____ TB _____ Hepatitis B _____

Height: _____ (date) Weight: _____ (date)

Other pertinent data the physician should be aware of:

I hereby authorize the release of all medical information pertaining to this work related injury/illness to my employer, insurance company and referral physicians. Records from any medical provider involved in or relative to the diagnosis or treatment of this injury may be released to St. Elizabeth Business Health Center. In addition, authorization is hereby given to this treating facility to perform any and all tests or procedures relative to my injury/illness or physical examination as deemed necessary by the attending physician and/or employer.

In the event my treatment/tests are not work-related, I accept responsibility for payment.

Signature _____ Date _____

