REGISTRATION FORM

PLEASE FILL OUT ALL SECTIONS COMPLETELY

PATIENT INFORMATION

Name:_____ Prefer to be called: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ / _____ / _____

Email Address:_____ Social Security Number:_____

Address: _____ City: _____ Zip Code: _____

Phone: Home _____ Cell _____ Work _____

Preferred Contact Number: ☐ Home ☐ Cell ☐ Work May we contact you via text? ☐ Yes ☐ No

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Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Partnered

Ethnicity: ☐ Caucasian ☐ African American ☐ Asian ☐ Native American ☐ Other:_____

Employment status: ☐ Currently Employed ☐ Retired ☐ On Disability ☐ Student ☐ Unemployed

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Emergency Contact Name: _____ Emergency Contact Number: _____

Primary Care Physician: _____ Primary Care Phone: _____

Referring Physician: _____ Referring Physician Phone: _____

Primary Insurance: _____ Member ID:_____

Policy Holder Name: _____ Policy Holder Date of birth: _____
(if not self) (if not self)

Secondary Insurance: _____ Member ID: _____

You must provide a valid picture ID and your insurance cards at the time of visit, as well as any referrals required by your insurance company.

MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____

Recent Symptoms (Please check all that apply)

☐ Abdominal Pain	☐ Discolored toes	☐ Heartburn	☐ Numbness	☐ Shortness of Breath
☐ Blood in stool	☐ Dry Eyes	☐ Joint Pain	☐ Pain in eyes	☐ Tingling
☐ Chest Pain	☐ Dry Mouth	☐ Morning Stiffness	☐ Pain w/ urination	☐ Vomiting
☐ Diarrhea	☐ Fevers	☐ Mouth Sores	☐ Palpitations	☐ Weakness
☐ Discolored fingers	☐ Hair loss	☐ Nausea	☐ Rash	☐ Weight loss

Personal Medical History (Please check all that apply)

☐ Asthma	☐ Celiac	☐ Heart Disease	☐ MS	☐ Psoriasis	☐ Cancer
☐ Anemia	☐ Cholesterol	☐ High cholesterol	☐ Myositis	☐ Rheum Arthritis	☐ Diabetes
☐ AFIB	☐ COPD	☐ High Blood Pressure	☐ Osteoarthritis	☐ Sarcoidosis	☐ IBS
☐ Barretts Esoph	☐ Fibromyalgia	☐ Kidney Disease	☐ Osteoporosis	☐ Scleroderma	☐ Pancreatitis
☐ Bronchitis	☐ Gout	☐ Lyme Disease	☐ Pseudogout	☐ Tendonitis	☐ Stroke / TIA
☐ Carpal Tunnel	☐ Heartburn	☐ Lupus	☐ Psoriatic Arth	☐ Ulcer Colitis	☐ Thyroid

Other (Please list): _____

_____

Surgical History: _____

_____

Family History - Please select or list known conditions of parents, siblings, or grandparents

☐ Rheumatoid Arthritis ☐ Psoriasis ☐ Lupus ☐ Vasculitis ☐ Gout

Other: _____

_____

Diet

☐ Coffee consumption ☐ Soda consumption ☐ Tea Consumption ☐ Gluten Free Diet ☐ Vegetarian Diet

Social History

Smoking Status: ☐ Non Smoker ☐ Former Smoker ☐ Current Smoker - packs per day: _____

Alcohol Use: ☐ No ☐ Yes - Drinks per day: _____

Illegal Drug Use: ☐ No ☐ Yes -Please list: _____

Rheumatology and Arthritis Care Center

Patient Assessment

1. Please check the ONE best answer that describes your abilities at this time:

OVER THE LAST WEEK, were you able to:	Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE to do
Dress yourself, including tying shoelaces and doing buttons?	____ 0	____ 1	____ 2	____ 3
Get in and out of bed?	____ 0	____ 1	____ 2	____ 3
Lift a full cup or glass to your mouth?	____ 0	____ 1	____ 2	____ 3
Walk outdoors on flat ground?	____ 0	____ 1	____ 2	____ 3
Wash and dry your entire body?	____ 0	____ 1	____ 2	____ 3
Bend down to pick up clothing from the floor?	____ 0	____ 1	____ 2	____ 3
Turn regular faucets on and off?	____ 0	____ 1	____ 2	____ 3
Get in and out of a car, bus, train, or airplane?	____ 0	____ 1	____ 2	____ 3
Walk two or three kilometers, if you wish?	____ 0	____ 1	____ 2	____ 3
Participate in recreational activities and sports as you would like?	____ 0	____ 1	____ 2	____ 3
Get a good night sleep?	____ 0	____ 1.1	____ 2.2	____ 3.3
Deal with feelings of anxiety or being nervous?	____ 0	____ 1.1	____ 2.2	____ 3.3
Deal with feelings of depression or feeling blue	____ 0	____ 1.1	____ 2.2	____ 3.3

Please answer the following on a scale of 0-10 (**0 = No pain at all**, **10 = The worst pain you have experienced)**

2. How much pain have you had because of your condition OVER THE PAST WEEK? (0-10) _____

3. Considering all the ways in which illness and health conditions may affect you at this time, please indicate how you are doing. (0-10) _____