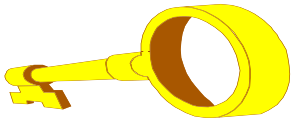


Key To Recovery Therapy Services, Inc.

7700 Old Branch Avenue Suite E-108
Clinton, Maryland 20735
Phone 301-856-3011
Fax 301-856-3013

PATIENT REGISTRATION

Name_____ D.O.B. _____

Address_____ City _____ State _____ Zip _____

Home _____ Work _____ Cell _____

Email: _____ SSN _____

Emergency Contact_____ Relationship_____

Home # _____ Work #_____ Cell #_____

Employer Information

Employer Name_____ Phone _____

Address, City, State, Zip_____

Insurance Information

Policy Guarantor _____ Relationship_____

Guarantor's Social Security # _____

Address, City, State, Zip_____

Phone/Cell _____

Primary Insurance _____ Secondary Insurance_____

Medical History

Referring Physician _____ Phone_____

Address_____

When do you see this physician next? _____

Past/Present Illnesses _____

_____

_____

Reason for coming to therapy_____

Current Medications _____

_____

_____

_____

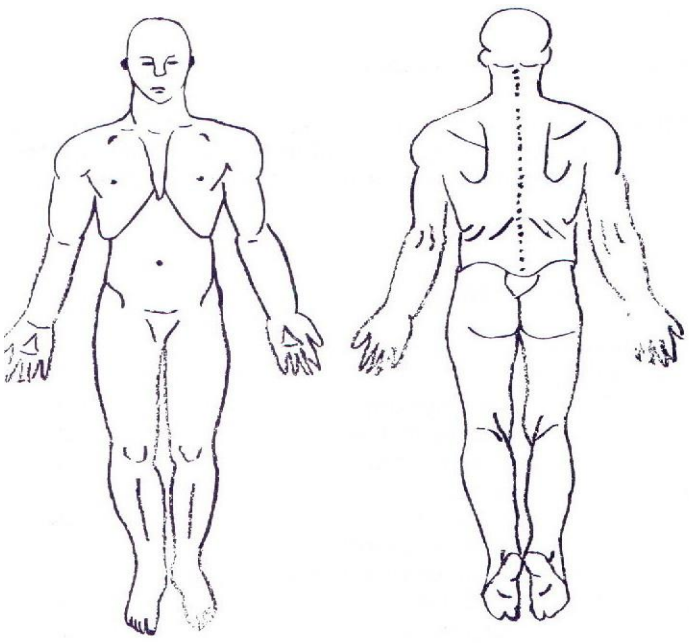
Is your current complaint due to an auto accident? No _____ Yes _____ State _____ Date of accident _____

Is your current complaint due to a work related injury? No _____ Yes _____ Date of injury _____

If no to both above, how & when did your problem begin?_____

What testing has been done & when? (x-ray, MRI)_____

Where does the pain start? (indicate where with an X on the diagram)Where does the pain spread to? (indicate with an → on the diagram)



Do you have any tingling, numbness or loss of skin sensation? (indicate where on diagram above)

On a scale of 0 - 10 (0 = no pain 10 = unbearable) Rate your pain now _____ at worse _____ at best _____

What makes your pain worse?_____

What gives you relief? _____

_____

Have you had any previous treatment for this condition? If yes, explain: _____

_____

_____

_____

Your signature below states that the information you have provided is true and accurate. Any false insurance information provided may result in you being fully billed and liable for all charges and fees for services rendered:

_____ _____

Signature Date