



PHYSICAL THERAPY + PERSONAL TRAINING

Today's Date: \_\_\_\_\_.

Personal Information

Name \_\_\_\_\_; Signature: \_\_\_\_\_
Phone: \_\_\_\_\_; Cell: \_\_\_\_\_
Address: \_\_\_\_\_; City: \_\_\_\_\_; State: \_\_\_\_; Zip: \_\_\_\_
School/Employer: \_\_\_\_\_; e-mail: \_\_\_\_\_
D.O.B.: \_\_\_\_\_; Primary Physician: \_\_\_\_\_
Parent or Guardian: \_\_\_\_\_; Phone: \_\_\_\_\_
Emergency Contact: \_\_\_\_\_; Phone: \_\_\_\_\_; Relationship: \_\_\_\_\_
Marital Status: \_\_\_\_\_.

Cancellation fee of \$65.00 within 24 hours of appointment time.

Current Health Condition

Referred By: \_\_\_\_\_.

Main or Primary complaint: \_\_\_\_\_

Previous occurrences: \_\_ Yes: \_\_ No
When did this condition begin: \_\_\_\_\_
Have you seen a doctor for this condition? \_\_\_\_\_. If yes, who: \_\_\_\_\_
When do you return to the doctor for follow up? \_\_\_\_\_
Have you had surgery for this condition? \_\_\_\_\_. If yes, when: \_\_\_\_\_
On a pain level of 0-10 (10 being excruciating) how painful was condition when started? \_\_\_\_\_
What is pain level at its best? \_\_\_\_\_. Worst? \_\_\_\_\_.
What is pain level today? \_\_\_\_\_. How would you describe pain? \_\_\_\_\_
What is concerning you most: \_\_\_\_\_

Please list any special test and results for this condition (MRI, X-ray, Bone scan etc.): \_\_\_\_\_

How is the pain/injury interfering with daily life: \_\_\_\_\_

Please list current physical activity: \_\_\_\_\_

Please list prior and current treatment/therapy for this condition: \_\_\_\_\_

Past Health History

Check any that apply

- \_\_ high blood pressure \_\_ heart attack \_\_ heart condition \_\_ diabetes \_\_ fainting spells \_\_ surgeries \_\_ back problems \_\_ fractures \_\_ chronic pain \_\_ muscle or joint pain \_\_ arthritis \_\_ tendonitis \_\_ scoliosis \_\_ seizures \_\_ stroke \_\_ cancer \_\_ pacemaker \_\_ metal implants \_\_ headaches