IROC

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 $50.00 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