Client Demographic Information

Today's Date:_____

FYZICAL Therapy & Balance Centers

Name: _____ Date of Birth:_____
Phone Number: _____ Emergency Contact(Name and Phone): _____
Email: _____ _____
How did you hear about us? ☐ Doctor ☐ Friend ☐ Internet ☐ Other_____
How would you like to receive reminders about your appointment? ☐ Text ☐ Phone call ☐ Email
Occupation_____ Work status? _____
Dominant hand ☐ Right ☐ Left ☐ Ambidextrous

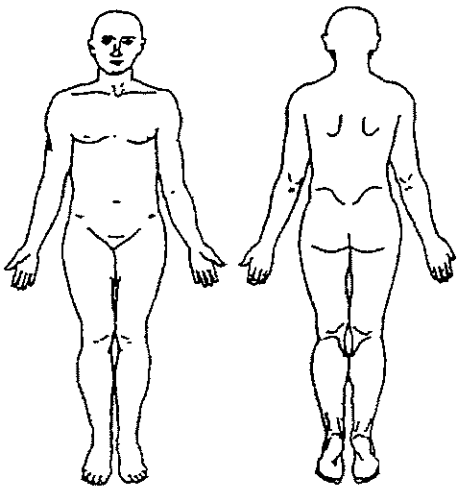
Have you fallen in the last year? ☐ Yes ☐ No If yes, were you injured? ☐ Yes ☐ No describe _____
How much physical activity or exercise per week? ☐ 30+ minutes 5+days/week ☐ 30+min 3-5 days/wk
☐ 30+min 1-3 days/wk ☐ less than 30 minutes 1-3 days/wk ☐ not regularly exercising ☐ Other _____
Are you interested in learning about how a medically based fitness program can safely optimize your health?
☐ Yes ☐ No

What daily activities are you having difficulty performing? _____
What are your goals for physical therapy? _____
Do you have difficulty hearing? ☐ Yes ☐ No Do you have hearing aids? ☐ Yes ☐ No

Symptom Questionnaire

What problem or issue brings you here? _____
How and when did it start? _____
Did you have surgery? ☐ Yes ☐ No Procedure: _____ Date of surgery? _____
What tests have you had? ☐ X-ray ☐ MRI ☐ CT scan ☐ EMG ☐ Bone scan ☐ Other _____
What treatments have you had? ☐ Physical Therapy ☐ Massage ☐ Chiropractic ☐ Other _____

Mark or shade the locations of your pain on the picture below



Please describe your pain or chief symptoms: (check all that apply)

☐ Vertigo, room spinning
☐ Light headedness
☐ Imbalance
☐ Ear pressure/pain
☐ Motion intolerance
☐ Headaches/migraine
☐ Head injury/concussion
☐ Tingling
☐ Burning
☐ Shooting
☐ Throbbing
☐ Dull pain / ache
☐ Sharp pain

Please describe the intensity and pattern of symptoms:

Symptoms are...
☐ Getting better
☐ Not changing
☐ Getting worse

Symptoms are worse...
☐ Morning
☐ Afternoon
☐ Night
☐ Constant

Activities/positions that increase symptoms_____
Activities/positions that decrease symptoms_____

Place marks on lines to indicate your level of pain/ symptoms
0= no pain/symptoms 5= symptoms cause you to stop activities 10= must go to hospital

Please rate your **CURRENT** level of pain or symptoms on the line below

0 1 2 3 4 5 6 7 8 9 10

Please rate your **BEST** level of pain or symptoms on the line below

0 1 2 3 4 5 6 7 8 9 10

Please rate your **WORST** level of pain or symptoms on the line below

0 1 2 3 4 5 6 7 8 9 10

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Do you have a pacemaker? ☐ Yes ☐ No Do you have high blood pressure? ☐ Yes ☐ No What is usual BP? _____
Do you have any joint replacements or metal implants? ☐ Yes ☐ No Please list types and dates: _____

Do you have a history of cancer or tumors? ☐ Yes ☐ No Please describe type and date: _____
_____ Chemotherapy ? ☐ Yes ☐ No Radiation ? ☐ Yes ☐ No

Recent night pain or fevers/ sweats	☐ Yes ☐ No	Vision change or double vision	☐ Yes ☐ No
Unintentional weight change	☐ Yes ☐ No	Shortness of breath?	☐ Yes ☐ No
New rashes / psoriasis?	☐ Yes ☐ No	Sleep problems?	☐ Yes ☐ No
Depressed mood?	☐ Yes ☐ No	Anxiety?	☐ Yes ☐ No
Joint swelling?	☐ Yes ☐ No	Nausea, vomiting, bowel or bladder changes?	☐ Yes ☐ No

History of tobacco use? ☐ Never ☐ Yes ☐ Quit ☐ Current ☐ Cigarette packs/day _____☐ Cigar ☐ Pipe ☐ Chew
Number of caffeinated drinks per day? _____ Alcohol use? ☐ Yes ☐ No if Yes, drinks per week?_____
Do you leak urine, even a small amount? ☐ Yes ☐ No Do you have to rush to use the bathroom? ☐ Yes ☐ No

WOMEN: Currently pregnant? ☐ Yes ☐ No Est. date of delivery_____ Number of pregnancies? _____
Number of vaginal deliveries? _____ Number of C-sections? _____Date of last menstrual period? _____
Hysterectomy? ☐ Yes ☐ No Date_____ Pelvic organ prolapse? ☐ Yes ☐ No Type _____

Medical History and Family History. If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column. If you have a family history of a condition, check it in the FAMILY column. The information you provide concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.

CONDITION	PAST	PRESENT	FAMILY	CONDITION	PAST	PRESENT	FAMILY
Angina	☐	☐	☐	Systemic Lupus	☐	☐	☐
Chest pain	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Heart Attack	☐	☐	☐	Osteoarthritis	☐	☐	☐
Cardiac Problems	☐	☐	☐	Osteoporosis	☐	☐	☐
Stroke/TIA	☐	☐	☐	Peripheral neuropathy	☐	☐	☐
Blood clot	☐	☐	☐	HIV/AIDS	☐	☐	☐
Asthma / Respiratory	☐	☐	☐	Hepatitis	☐	☐	☐
Emphysema	☐	☐	☐	Infectious diseases	☐	☐	☐
Diabetes	☐	☐	☐	Epilepsy / seizures	☐	☐	☐
Fibromyalgia	☐	☐	☐	Lower limb edema/swelling	☐	☐	☐

Other Present or Past Medical Conditons:_____

Medications- For additional room provide a list medications

Name	Reason for taking	Dosage

Hospitalization/Surgical Procedures (not described elsewhere): Additional surgeries provide a list please

Type	Date

Client Signature _____ Date_____