Client Demographic Information

Today's Date:_____

FYZICAL Therapy & Balance Centers

Name: _____ Date of Birth:_____

Occupation_____ Work status? _____

Have you fallen in the last year? ☐ Yes ☐ No If yes, were you injured? ☐ Yes ☐ No describe

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 _____

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_____

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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

WOMEN: Currently pregnant? ☐ Yes ☐ No Est. date of delivery_____

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
Hypertension	☐	☐	☐	Systemic Lupus	☐	☐	☐
Chest pain Heart	☐	☐	☐	Rheumatoid Arthritis	☐	☐	☐
Attack Cardiac	☐	☐	☐	Osteoarthritis	☐	☐	☐
Problems Stroke/	☐	☐	☐	Osteoporosis	☐	☐	☐
TIA Blood clot	☐	☐	☐	Peripheral neuropathy	☐	☐	☐
	☐	☐	☐	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_____