Name: _____ Date of Birth: _____

Address: _____

Home Phone Number: _____ Cell Phone Number: _____

Email: _____

Emergency Contact Name and Relationship: _____

Emergency Contact (Phone Number): _____

How did you hear about us? ☐ Doctor ☐ Friend ☐ Internet ☐ Other_____

Marital Status_____ Occupation_____ Working ☐ Yes ☐ No

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

What daily activities are you having difficulty performing?

_____

What are your goals for physical therapy?

_____

Do you leak urine, even a small amount? ☐ Yes ☐ No Do you have to rush to use the bathroom? ☐ Yes ☐ No

Do you have difficulty hearing? ☐ Yes ☐ No Do you have hearing aids? ☐ Yes ☐ No

Symptom Questionnaire

What problem or issue brings you here? _____

Did you have surgery? ☐ Yes ☐ No Procedure: _____ Date _____

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

WOMEN Currently pregnant? ☐Yes ☐No If Yes, 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 organs prolapse? ☐Yes ☐No

Type _____

Medications- If additional space is needed, please provide a medications list.

Name	Reason for taking	Name	Reason for taking
_____		_____	
_____		_____	
_____		_____	

Medical History The information you provide concerning past and present condition(s) and diseases assists your doctor in more thoroughly understanding your state of health. Please check any that apply

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

Other Medical Conditions: _____

Hospitalization/Surgical Procedures (not described elsewhere): If more space is needed, please provide list Type / Date_____
_____
_____

Consent for Treatment: I hereby consent to receive care for therapy services by FYZICAL. I consent to medical treatment as deemed necessary or advisable by the physical therapist.

Consent to Release Medical Information: I authorize FYZICAL to release any information acquired in connection with my therapy services including but not limited to diagnosis and clinical records to myself, my insurance(s), physician(s), and _____.

Consent to obtain Medical Information: I authorize FYZICAL to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician documentation.

Assignment of Insurance Benefits: I hereby authorize payment to be made directly to FYZICAL.

Guarantee of Payment: I agree to pay charges that my insurance does not pay. I am responsible to pay any un-covered portion on the dates of service rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees.

I hereby certify that I understand these rights as set forth.

Patient/ Responsible Party Signature _____ Date_____