FYZICAL®
Therapy & Balance Centers

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Soc. Sec. #: _____ Email: _____

Street Address: _____ City: _____ Zip: _____

Marital Status: Married ___ Single ___ Divorced ____ Widowed ____ Other _____

Home Phone: (____) _____ Work Phone: (___) _____

Cell Phone: (___) _____ Other Phone: (___) _____

Employer Name: _____

Work Address: _____ City: _____ Zip: _____

How did you learn about *FYZICAL*?: _____

May we send appointment reminders & billing statements to you via email and/or text message (standard rates may apply, contact your mobile carrier for details*) Check all that apply: *E-mail _____ *Text Message _____**

Emergency Contact Information

Name of Contact: _____ Relationship: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Work Phone: (____) _____ Other Phone: (____) _____

Insurance Information

Primary Insurance: _____

Name of Insured if other than Patient: _____ DOB: _____

Relationship to Insured: _____ ID number: _____

Secondary Insurance: _____

Name of Insured if other than Patient: _____ DOB: _____

Relationship to Insured: _____ ID number: _____

<<See Reverse Side>>

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Release of Medical Information

Referring Physician: _____

I have had diagnostic tests or surgical procedures performed and grant my physician: _____ to release the following reports to *FYZICAL.*

Types of tests performed:_____ Date:_____
:_____ Date:_____
:_____ Date:_____

I hereby authorize *FYZICAL* to release any medical information regarding this injury/condition to the following:

- **My health insurance company**
- **Referring Physician (listed above)**
- **Workers' Compensation carrier/employer (If Workers' Compensation injury)**
- **Family Members (list below, please provide relationship and phone number):**
  - _____
  - _____

Signature: _____ Date:_____

Relationship if other than patient: _____

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Patient Medical History

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your initial assessment examination. This form is considered part of your medical record.

Patient Name: **DOB:**

1	**When was your last health check up?**			**Date:**
2	**Who is your family doctor?**			
3	**Have you ever been told that you have:**			**Therapist Comments:**
High Blood Pressure	**Yes**	**No**		
Heart Problems	**Yes**	**No**		
Lung Problems	**Yes**	**No**		
Kidney Problems	**Yes**	**No**		
Head Injury	**Yes**	**No**		
Stroke/Neurological Problems	**Yes**	**No**		
Liver Problems	**Yes**	**No**		
Thyroid Problems	**Yes**	**No**		
Blood Disorders	**Yes**	**No**		
Diabetes (High Blood Sugar)	**Yes**	**No**		
Low Blood Sugar	**Yes**	**No**		
Past Fractures/Dislocations	**Yes**	**No**		
Asthma	**Yes**	**No**		
Seizure	**Yes**	**No**		
Cancer	**Yes**	**No**		
Arthritis	**Yes**	**No**		
Shingles	**Yes**	**No**		
Ringing Ears	**Yes**	**No**		
Tuberculosis or Hepatitis	**Yes**	**No**		
Repeated Infections	**Yes**	**No**		
Depression	**Yes**	**No**		
Osteoporosis	**Yes**	**No**		
Circulation/Vascular Problems	**Yes**	**No**		
Ulcer/Stomach Problems	**Yes**	**No**		
4	**Home Health Services:**			
Are you currently being seen by them for any reason?	**Yes**	**No**		
5	**For Men Only:**			
Prostate Disease	**Yes**	**No**		
6	**For Women Only:**			
Pelvic Inflammatory Disease	**Yes**	**No**		
Endometriosis	**Yes**	**No**		
Are you Pregnant?	**Yes**	**No**		

<< See Reverse Side >>

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7	**Within the last 6 months have you had:**			
	Unexplained Weight Loss/Gain	**Yes**	**No**	
	Loss of Appetite	**Yes**	**No**	
	Unexplained Fever or Chills	**Yes**	**No**	
	Unremitting Night Pain	**Yes**	**No**	
	Joint Pain or Swelling	**Yes**	**No**	
	Urinary or Bowel Problems	**Yes**	**No**	
	Fatigue/Malaise/Tiredness	**Yes**	**No**	
	Numbness or Tingling	**Yes**	**No**	
	Weakness in the Arms or Legs	**Yes**	**No**	
	Recent Falls or Loss of Balance	**Yes**	**No**	
	Coordination Problems	**Yes**	**No**	
	Difficulty Walking	**Yes**	**No**	
	Dizziness or Loss of Consciousness	**Yes**	**No**	
	Chest Pain	**Yes**	**No**	
	Heart Palpitations	**Yes**	**No**	
	Shortness of Breath	**Yes**	**No**	
	Difficulty Swallowing	**Yes**	**No**	
	New Onset of Headaches	**Yes**	**No**	
	Visual Problems	**Yes**	**No**	
	Hearing Problems	**Yes**	**No**	
	Hoarseness	**Yes**	**No**	
	Cough	**Yes**	**No**	
8	Do you smoke?	**Yes**	**No**	If yes, how many? Packs/Day
9	**List Any Hospitalizations/Surgeries:**			
10	**List Any Other Medical Problems:**			
11	**List Any Allergies:**			
12	**List Your Current Medications:** _____			
13	Have you had a bone density test?	**Yes**	**No**	
14	Do you feel your overall health is: (Check one) ___**Excellent** ___**Good** ___**Fair** ___**Poor**			
15	Reviewed By:			

I certify that the above information is accurate to the best of my knowledge:

Signature:_____ **Date:**_____