FYZICAL® RALEIGH
Therapy & Balance Centers

Today's Date: _____

Name: _____ Date of Birth: _____ SSN: _____

Preferred Name:_____ Preferred Pronouns: ☐ He/ Him ☐ She/ Her ☐ They/ Them

Phone Number: _____ Email: _____

Home Address: _____

Emergency Contact (Name and Phone): _____

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 Height: _____ Weight:_____

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

What problem or issue brings you here? _____

What daily activities are you having difficulty performing? _____

What are your goals for physical therapy? _____

How and when did this issue start? _____

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

_____

What tests have you had? ☐ X-ray ☐ MRI ☐ CT scan ☐ EMG ☐ Bone scan ☐

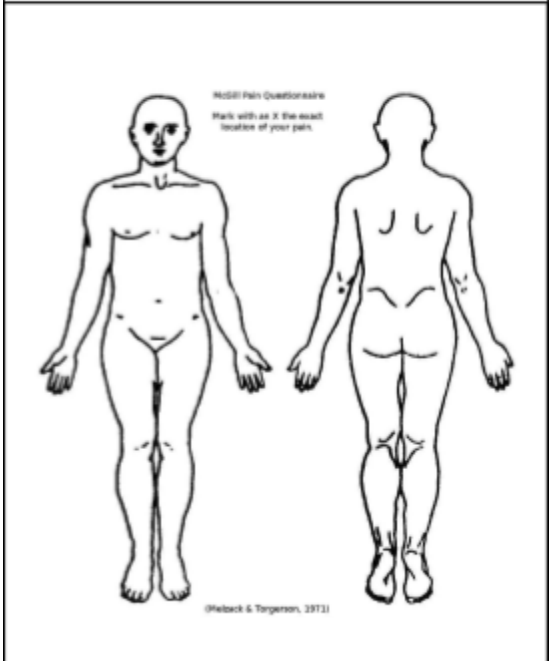
Other_____

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

Activities/positions that increase symptoms

**Please describe the intensity and pattern of symptoms:**

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

☐ Morning
☐ Afternoon
☐ Night
☐ Constant

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_____

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----

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

Do you have a pacemaker? ☐ Yes ☐ No

Do you have high blood pressure? ☐ Yes ☐ No Usual BP? _____

Do you have any joint replacements or metal implants? ☐ Yes ☐ No

Please list type and date:_____

Do you have a history of cancer or tumors? ☐ Yes ☐ No

Please list type and date: _____

Chemotherapy? ☐ Yes ☐ No Radiation? ☐ Yes ☐ No

Do you leak urine, even a small amount? ☐ Yes ☐ No

Do you have to rush to use the bathroom? ☐ Yes ☐ No

**Do you currently experience any of the following?**

| | | | |
|---|---|---|---|
| Recent night pain or fevers/ sweats | ☐ Yes ☐ No | New rashes / psoriasis | ☐ Yes ☐ No |
| Vision change or double vision | ☐ Yes ☐ No | | |
| Unintentional weight change | ☐ Yes ☐ No | | |
| Shortness of breath | ☐ Yes ☐ No | Sleep problems | ☐ Yes ☐ No |

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Depressed mood ☐ Yes ☐ No

Anxiety ☐ Yes ☐ No

Joint swelling ☐ Yes ☐ No

Nausea, vomiting, bowel or bladder changes ☐ Yes ☐ No

WOMEN: Pregnant? ☐ Yes ☐ No Est. date of delivery:_____ Number of pregnancies? _____

**Medical 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 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 | CONDITION | PAST | PRESENT |
|---|---|---|---|---|---|
| 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 Conditions: _____

**Current Medication List**:

_____

_____

_____

_____

_____

_____

_____

_____

_____

*Please be advised we may have the medication list on file if you were referred from a physician's office, feel free to verify with the front desk if it is already on file. Thank you.*

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Client Signature _____ Date_____