Client Demographic Information

Today's Date:_____

FYZICAL Therapy & Balance Centers

Name: _____ Date of Birth:_____
Phone Number: _____
Emergency Contact (Name, Relation & Phone)_____

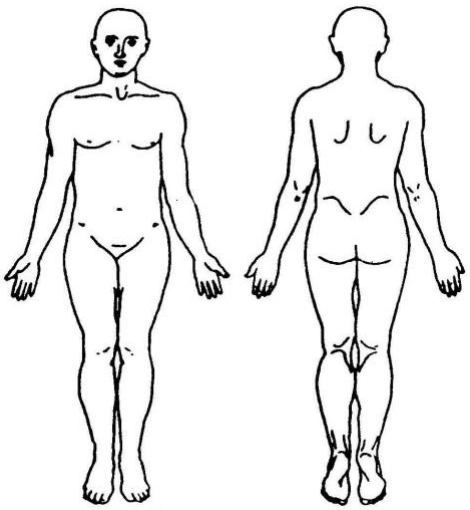
How did you hear about us? ☐ Doctor ☐ Friend ☐ Internet ☐ Other_____
How would you like to receive reminders about your appointment? ☐ Text ☐ Email
Cell phone number: (____)_____-_____Cell phone company:_____
Email Address: _____

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 _____
What daily activities are you having difficulty performing? _____
What are your goals for physical therapy? _____

Symptom Questionnaire

What problem or issue brings you here? _____
Onset date of pain: _____
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
Nausea, vomiting, Bladder changes?	☐ Yes ☐ No	New rashes / psoriasis?	☐ Yes ☐ No
Depressed mood?	☐ Yes ☐ No	Anxiety?	☐ Yes ☐ No
Sleep problems?	☐ Yes ☐ No	Joint swelling?	☐ Yes ☐ No

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	☐	☐	☐	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	☐	☐	☐

Medications- For additional room provide a list of medications

Name Reason for taking Dosage

_____
_____
_____
_____

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

Type Date

_____
_____
_____
_____

Client Signature _____ Date_____