FYZICAL®
Therapy & Balance Centers

Last Name:_____
First Name:_____
Middle Initial:_____
Street Address:_____
City:_____
State:_____
Zip:_____
Sex:_____
Date of Birth:_____
Social Security Number:_____
Phone Number: _____
Email: _____
Emergency Contact(Name and Phone): _____
Marital Status:
Single:_____Married:_____Divorced:_____Widowed:_____
Primary Care Physician/Family Doctor(s):_____
Are you currently under care of a Home Health Agency? Yes_____No_____
Name of Home Health Agency (if Yes):_____
Reason for visit: Physical Therapy:_____ BodyQ:_____ FyzFit Sessions:_____
How did you hear about us? □ Doctor □ Friend □ Internet □
Other: _____
How would you like to receive Reminders about your Appointments?
□ Text □ Phone call □ Email
Occupation:_____ Work status? _____
Dominant hand □ Right □ Left □ Ambidextrous

Client Signature: _____ Date:_____