designing fitness
physical therapy
Therapeutic exercise and massage for lifelong wellness

Client Information

Name:_____Date of Birth:_____
Address:_____
City:_____State:_____Zip Code:_____
Telephone:_____
Email address:_____
Emergency Contact:_____Telephone:_____
Primary Care Provider:_____Telephone:_____
Referring Provider:_____Telephone:_____
Occupation/Hobbies:_____
How did you hear about Designing Fitness Physical Therapy?
Doctor Friend/Family Insurance Internet Mail

Medical Insurance Information

Policy Holder if other than patient:_____
Relationship to patient:_____
Primary Insurance:_____Policy #:_____
Secondary Insurance:_____Policy #:_____

Medical History

Reason for today's visit:_____
Related to car accident? Yes No Work-related? Yes No
Have you had any of these tests?
X-Ray MRI CAT Scan Bone Scan Nerve/Muscle Test Other
Who is involved in your care for this problem currently?
Primary Care Provider Specialist Chiropractor Other_____
Have you had any falls in the past year? Yes No
Are you currently receiving medical treatment for any other problem? Yes No
If so, please elaborate:_____

Please check below if you have any of the following conditions:

____arthritis/joint pain
____osteoporosis
____bursitis/tendonitis
____gout
____broken/fractured bones
____sprains/strains
____low back/hip/leg pain
____neck/shoulder/arm pain
____headaches/head injuries
____jaw pain/TMJ
____warts
____rash
____athletes foot
____sinus problems/allergies
____herpes/shingles
____chronic pain
____chronic fatigue
____diabetes
____depression
____pregnancy

____high/low blood pressure
____neurological disease/issues
____cardiac/heart problems
____stroke/TIAs
____infectious disease (TB, HIV, AIDS, Hepatitis)
____anticoagulant use/bruise easily
____pulmonary/lung disease
____joint replacement: year_____
____impaired memory
____epilepsy/seizures
____blood clots
____pacemaker/implants
____open wounds
____sleep disorder
____high/frequent stress
____vision problems
____dizziness/vertigo
____hearing problems
____other disease:_____
____Allergies:_____
____Recent surgery:_____Date of surgery:_____
____Cancer:_____Date of diagnosis:_____
Please check if in treatment:____Chemo____Radiation____Hormonal____other

Have you received physical/occupational/speech therapy or chiropractic care earlier this calendar year? Yes No
If so, from whom and for what problem?
_____

Please list your current medications, or provide a list:
_____
_____
_____
_____

The information I have provided above is accurate to the best of my knowledge. I have notified my therapist of whether or not I suffer any serious illness/condition that may affect my treatment or treatment outcomes.

Client Signature:_____Date:_____
Parent/Guardian (if Minor):_____Date:_____
Witness:_____Date:_____

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