Client Demographic Information

Today's Date:___________________

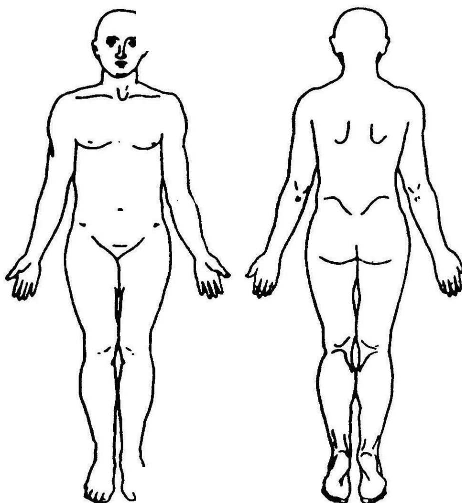
Name: _________________________________ Date of Birth:______________________________________
Phone Number: ___________________________ Emergency Contact(Name and Phone): _________________
Email: __________________________________ ____
How did you hear about us? ☐ Doctor ☐ Friend ☐ Internet ☐
Other____
How would you like to receive reminders about your appointment? ☐ Text ☐ Phone call ☐ Email
Occupation_______________________________ Work status? ______________________________
Dominant hand ☐ Right ☐ Left ☐ Ambidextrous

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/wk ☐ 30+min 3-5 days/wk
☐ 30+min 1-3 days/wk ☐ less than 30 minutes 1-3 days/wk ☐ not regularly exercising ☐ Other _______________
Are you interested in learning about how a medically based fitness program can safely optimize your health?
☐ Yes ☐ No
What daily activities are you having difficulty performing? ____
What are your goals for physical therapy? ____
Do you have difficulty hearing? ☐ Yes ☐ No Do you have hearing aids? ☐ Yes ☐ No

Symptom Questionnaire

What problem or issue brings you here? ____
How and when did it 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
☐ 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____________________________

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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 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
New rashes / psoriasis?	☐ Yes ☐ No	Sleep problems?	☐ Yes ☐ No
Depressed mood?	☐ Yes ☐ No	Anxiety?	☐ Yes ☐ No
Joint swelling?	☐ Yes ☐ No	Nausea, vomiting, bowel or bladder changes?	☐ Yes ☐ No

History of tobacco use? ☐ Never ☐ Yes ☐ Quit ☐ Current ☐ Cigarette packs/day ______☐ Cigar ☐ Pipe ☐ Chew

Number of caffeinated drinks per day? ____________ Alcohol use? ☐ Yes ☐ No if Yes, drinks per week?______

Do you leak urine, even a small amount? ☐ Yes ☐ No Do you have to rush to use the bathroom? ☐ Yes ☐ No

WOMEN: Currently pregnant? ☐ Yes ☐ No Est. date of delivery_______________ Number of pregnancies? ________

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	☐	☐	☐	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:____

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Medications- For additional room provide a list medications

Name Reason for taking Dosage

____
____
____
____
____

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

Type Date

____
____
____
____
____

Client Signature ____ Date________________