Functional Fitness
and Physical Therapy, LLC

Client Information and Health History Questionnaire

Client Information

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____ Marital status:_____

Mobile Phone:_____ Home Phone:_____

Emergency contact:_____ Phone:_____

As a courtesy we will provide a reminder of your scheduled appointments, how would you like to be notified?: Phone call☐ Text☐ Email☐

Email (to be used for appointment reminders): _____

Currently Employed?: yes☐ no☐ Occupation:_____

Referral from Physician: yes☐ no☐ If yes, name of Physician:_____

Physician Phone:_____ Date of next appointment:_____

Health Insurance:_____ ID #:_____

Subscriber of Health Insurance:_____ Date of Birth:_____

Is this injury or condition related to a work or motor vehicle accident (check one)?: yes☐ no☐

Current Condition

What is your reason for this visit:_____

When did your pain/condition begin?: _____

Have you had any episodes of similar problem(s) in the past, if so when?_____

List any medical tests or procedures/surgeries performed for **this** injury/condition:_____
_____

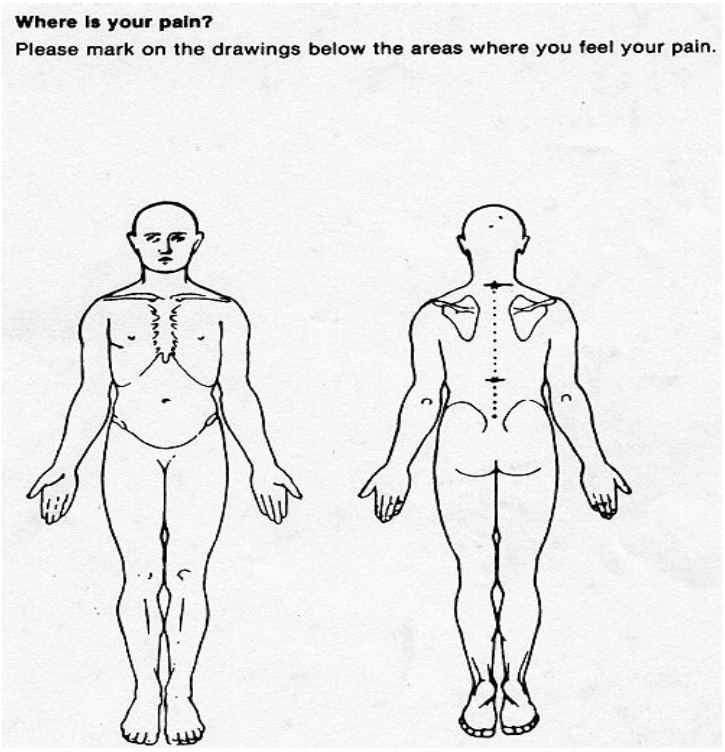
List any medications you are taking for **this** injury/condition:_____

Do you have any pain associated with **this** injury/condition?: yes☐ no☐

Pain at worst (circle the appropriate number): Pain Free - 0 1 2 3 4 5 6 7 8 9 10 -Severe

Pain at best: Pain Free- 0 1 2 3 4 5 6 7 8 9 10 -Severe

Current pain: Pain Free- 0 1 2 3 4 5 6 7 8 9 10 -Severe



Right Left Left Right

My pain can be described as (circle all that apply):
Burning Sharp Dull/Aching Throbbing Shooting Numbness/Tingling Constant Intermittent
Worse in a.m. Worse in p.m.

Is there anything that makes your pain/condition better?:_____

Please circle any factors that increase your pain or make your condition worse?:
Sitting Standing Walking Stairs-up Stair-down Getting up from chair Bending Lifting
Sleeping Driving Reading House-work Yard-work Recreation Voiding Coughing/sneezing

Please indicate any other activities or positions that increase your pain or make your condition worse:
_____

List any prior regular activities that you are unable to perform now due to your current condition:_____
_____

What do you do for activity or exercise now? _____

Health History

Allergies:_____

Please list ALL current medications, dosages and reason for taking (or provide list): _____
_____
_____
_____

List any previous surgeries and date: _____
_____

Do you have a History of (check box for prior history and circle any that are still present):

Heart disease☐
High blood pressure☐
Chest Pain☐
Stroke☐
Blood clot/Emboli☐
Pace maker☐
Heart Attack/Heart Surgery☐
Allergies☐
Diabetes☐
Fainting☐
Seizures☐
Cancer☐
Shortness of Breath☐
Respiratory problems☐
Pelvic Inflammatory Disease☐
Endometriosis☐
Interstitial Cystitis☐
Bowel or Bladder problems☐
Menstrual problems☐
Smoking☐
Arthritis☐

Weight loss☐
Energy loss☐
Vision or Hearing difficulty☐
Chronic pain☐
Leg cramps☐
Joint replacement☐
Osteoporosis☐
Backache/injury☐
Neckache/injury☐
Hip problems☐
Knee problems☐
Ankle problems☐
Foot problems☐
Shoulder problems☐
Elbow problems☐
Wrist or hand problems☐
Fractures☐
Headaches☐
Heartburn☐
Hernia☐
Numbness/tingling in hands☐

Additional concerns or comments about your past medical history:_____
_____

What would you like to accomplish by coming to Physical Therapy? _____
_____

How did you hear about Functional Fitness and Physical Therapy, LLC?_____

I agree that the above information is accurate and agree to inform my therapist of any changes to this information.

Client/Guardian Signature_____ Date_____