Functional Fitness
and Physical Therapy, LLC

Client Information and Health History Questionnaire

Client Information

Name:_____ Male/Female:____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip:_____

Mobile Phone:_____ Home Phone:_____

Emergency Contact:_____ Phone:_____

Relationship of Emergency Contact:_____

Appointment Reminders by **Text** □ **Email** □ **Phone call** □ (check one)

Email to be used for appointment reminders:_____

Currently Employed?: yes □ no □ Occupation:_____

Referral from Physician?: yes □ no □ Name of Physician:_____

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

Are you using health insurance or self-payment for PT services?: Insurance □ Self-pay □

Health Insurance (if billing insurance)

Insurance Company:_____ ID#:_____

Primary Care Physician:_____ Phone:_____

Subscriber of Health Insurance:_____ Date of Birth:_____

Address of Subscriber (if different):_____

Relationship to Subscriber:_____ Phone (if different):_____

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 past, if so when?:_____

List any medical tests or procedures/surgery and/or and any Physical Therapy or other therapies performed for **this** condition:_____

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

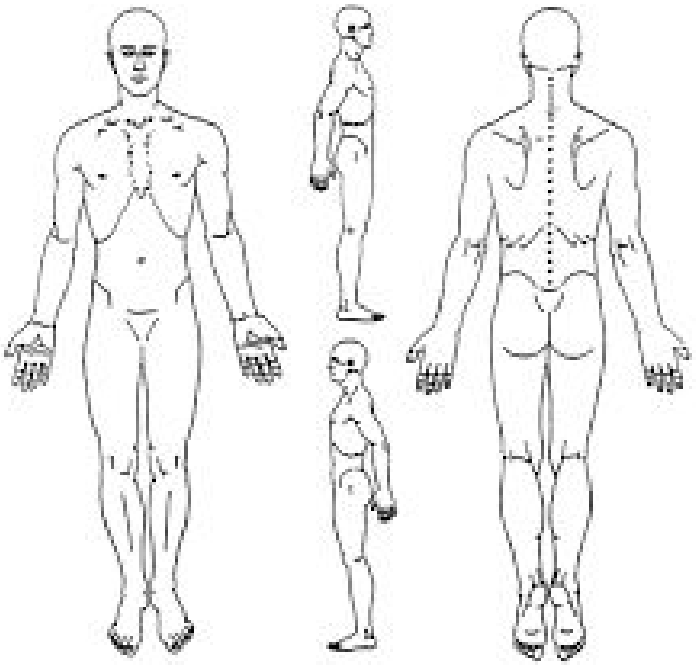
Pain at worst (circle): Pain Free- 0 1 2 3 4 5 6 7 8 9 10 -Severe

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

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

Pain and/or symptom location chart (please indicate location of your current pain or symptoms)

Right side



Right Left Left side 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:

_____

Health History

Do you now or have you ever had any of the following?	Yes	No		Yes	No
Heart Attack or Surgery			Dizziness or Fainting		
High Blood Pressure			Anxiety or Depression		
Cancer/Chemotherapy/Radiation			Hernia		
Asthma, Bronchitis or Emphysema			Bowel or Bladder Problems		
Shortness of Breath/Chest Pain			Severe or Frequent Headaches		
Diabetes			Osteoporosis/Osteopenia		
Hearing Difficulties			Stroke/TIA		
Vision Difficulties			Allergies		
Thyroid Issues			Eating Disorder		
Smoking			Joint Replacement		
Joint Pain/Arthritis			Pacemaker/Internal Defibrillator		
Sleep Disorder			Endometriosis/Pelvic Problems		
Currently Pregnant			If Pregnant, due date:		

Allergies:_____

Medications (please list all current medications or include list):_____

_____

List any previous surgeries and date: _____

_____

Additional concerns or comments about your past medical history:_____

_____

What do you do for activity or exercise now? _____

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:_____