***Welcome to our practice!***

***Please help us serve you better by taking a few minutes to provide the following information***.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  |  | Today’s date: |  |
| Last Name | First Name |
| Address: |  |
| City / State / ZIP: |  |  |  |
| Phone # | MOBILE |  | HOME |  | WORK |  |
| DOB: |  | Age: |  | Marital status: | M | S | W | D |
| Email: |  |
| Occupation: |  | Employer: |  |
| **Emergency Contact** | Name: |  | Phone: |  |
| **Primary Care Physician** | Name: |  | Date of next visit |  |
| **Specialist Physician** | Name: |  | Date of next visit |  |

***The following is very important in our evaluation process.***

***Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.***

|  |  |
| --- | --- |
| **What is the primary issue/problem that brings you in today?** | **Please shade in areas where you** h**ave pain, discomfort, or tension.** |
|  |
| **Secondary concern/problem?** |
|  |
| **As a result, I am now having difficulty with:** |
|  |
| **Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?** |
|  |
| **When did your symptom(s) begin? (Date):** |
|  |

|  |  |  |
| --- | --- | --- |
| **Please rate your pain in the last 24-72 hours****Using the “0 -10” scale where 0 is no pain and 10 is the worst possible pain.** | At its worst  |  |
| At its best |  |
| At present |  |
| Night (sleeping) |  |

|  |  |
| --- | --- |
| At what time of day are your symptoms the worst? |  |
| At what time of day are your symptoms the best? |  |
| What activities increase your pain? |  |
| What activities decrease your pain? |  |

|  |
| --- |
| **What other types of treatment have you had for this problem?** |
|  | Massage |  | Bodywork |  | Physical Therapy |  | Myofascial Release |  | Chiropractic |  | Surgery |
| Other Medical Treatment: (Please Describe) |  |

|  |
| --- |
| **Check the box if you have had any of the following medical conditions?** |
|  | Diabetes |  | Lung disease |  | Weight change |  | Varicose veins |  | Neurological problems |  | Pregnancy |
|  | Rheumatic fever |  | Osteoporosis |  | Migraine headaches |  | Epilepsy / seizures |  | Stroke |  | Blackouts |
|  | Heart Murmur |  | Malignancy |  | Arthritis |  | Broken bones /fracture |  | Metal implants |  | High blood pressure |
|  | Circulatory problems |  | Liver disease |  | Heart disease / pacemaker |  | Kidney disease |  | **Others (explain below)** |
|  |

|  |
| --- |
| **List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.** |
|  |
|  |
|  |

|  |
| --- |
| **List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).** |
| Medication | For treatment of | Dose / Amount per day | Effectiveness |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you smoke? | Yes | No | If “Yes” – How much? |  |
| When did you quit? |  | If not, Would you like to quit? |  |

|  |  |  |
| --- | --- | --- |
| Is there a chance you may be pregnant at this time? | Yes | No |

|  |  |  |
| --- | --- | --- |
| Do you engage in regular exercise? | Yes | No |
| What type and how often? |  |
| Are you able to exercise now? | Yes | No |

|  |  |  |
| --- | --- | --- |
| Do you have discomfort, shortness of breath, or pain with exercise? | Yes | No |
| Please Describe: |  |
| In general, your lifestyle is: | 1 | 2 | 3 | 4 | 5 |
| Active |  | Average |  | Inactive |

***If sleep is a problem, answer these questions:***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you have trouble falling asleep? | Yes | No | Do you find it difficult to change positions in bed? |  |
| Is your sleep restful? | Yes | No | How many times do you wake in the night? |  |
| Do you find it difficult to lie down? | Yes | No | How long before you fall back to sleep? |  |

**List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).**

**If you are no longer able to perform an activity, your tolerance would be “0”.**

|  |  |
| --- | --- |
| Task / Activity | Tolerance (minutes/hours) |
|  |  |
|  |  |
|  |  |

|  |  |  |
| --- | --- | --- |
| **I walk for** |  | **minutes before needing to rest** |
| **I stand for** |  | **minutes before needing to sit** |
| **I sit for** |  | **minutes before needing to change positions/get up** |
| **Do you have trouble getting up from a chair?** | Yes | No |
| **Do you have trouble putting on your shoes and socks?** | Yes | No |
| **Do you have difficulty climbing stairs?** | Yes | No |

**Patient Goals**

**Please list the activities that you would like to be able to do as a result of therapy.**

|  |
| --- |
|  |
|  |
|  |

***Informed Consent***

*I understand that Synergy Fitness for Her Physical Therapy will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.*

*I do hereby agree and give my consent for Synergy Fitness for Her Physical Therapy to provide care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.*

*I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.*

*I hereby certify that all the above information is true to the best of my knowledge.*

***Patient/Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_***