PATIENT INFORMATION

Please take a moment to completely fill out this form – Thank You!

(Please print)

Name ____

Address ____

City ________________________ State ________ Zip ______________

Cell Phone (______)__________________________

Home Phone (______)__________________________

Work Phone (______)__________________________

Email address ____

May we send you notices about events, specials, etc? Yes No

Emergency Contact:

Name ___________________________ Relationship ____________________

Phone # (______)_____________________________

How did you hear about us? (check one)

[ ] Referral who? _______________________________

[ ] Internet where? ______________________________

[ ] Advertisement where? _________________________

[ ] Other please indicate _________________________

Date of Birth _____/_____/_____ Age _______

Gender _______ Height _______ Weight _______

Referring Physician _________________________________ Phone # (______)_____________________

Diagnosis ____

Occupation ______________________________

Work demands (for example: 80% sitting, heavy lift/bending, airplane travel) _________________________

____

What **leisure & physical activities** do you participate in regularly? ____________________________________

____

What prior **pilates experience** have you had, if any? ____

Past Medical History: Do you or have you had any of the following? Circle Y = Yes, N = No

1. Heart Condition	Y	N		11. Sciatica	Y	N
2. COPD / Emphysema	Y	N		12. Sprain or Strain	Y	N
3. Asthma	Y	N		13. Bone Fracture	Y	N
4. Cancer	Y	N		14. High Blood Pressure	Y	N
5. Diabetes	Y	N		15. Stroke	Y	N
6. Thyroid Problems	Y	N		16. Hernia	Y	N
7. Epilepsy / Seizures	Y	N		17. Scoliosis	Y	N
8. Rheumatoid Arthritis	Y	N		18. Fainting or Dizzy Spells	Y	N
9. Osteoarthritis	Y	N		19. Eye or Ear Disorders	Y	N
10. Osteoporosis / Osteopenia	Y	N		20. Other	Y	N

Additional Comments (Please indicate question number) ____

____

____

Surgeries and/or physical injuries you have had (include dates) _____________________________________

____

Medications you are taking ____

Describe your **chief complaint** ____

Date of injury/Onset ____

Method/**History of injury** ____

____

Have you had **previous care** for your condition (for example: physical therapy, chiropractic, acupuncture, injections, massage)? ____

Have you had any **imaging studies** (X-rays, MRI, CT)? If yes, what were the findings? ___________________

____

What **aggravates** your symptoms (for example: sitting > 20 minutes on the couch, doing dishes/laundry, climbing 2 flights of stairs)? ____

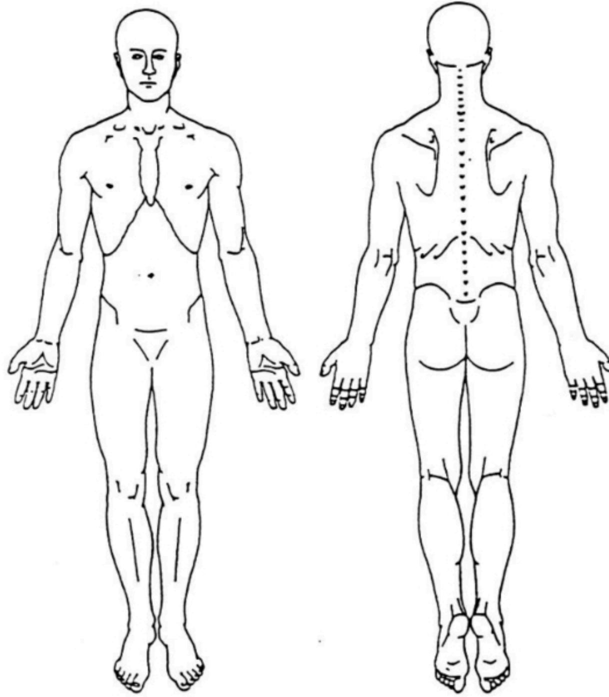
____

What **reduces** your symptoms (for example: hip stretches, ice, lying down)? ________________________________

____

Rate your **pain level** from 0-10 in the past week. 0 = none, 10 = excruciating _______

Indicate **present symptoms** (for example: pain, numbness, burning, weakness) and **location** on body diagram.



Please give 3 specific **physical therapy goals** (for example: able to drive 1 hour without leg numbness, return to playing tennis, bathe/lift 25 lbs. child without back strain).

1) ____

2) ____

3) ____

To the best of my knowledge, all of the above answers are true and correct. I understand it is my responsibility to inform the physical therapist of any changes.

Patient Signature _________________________________ Date ____________________

Therapist Signature _______________________________ Date ____________________