Name: ______________________________ DOB: ________________ Start of Care Date: ______________

Phone: _________________________ Email: ____

Address: ____

Emergency Contact: ______________________Relationship: ______________ Phone:__________________

Primary Care Physician / Phone Number: ____

Have you been treated for this condition before? Yes _____ No _____

If yes, where? ______________________and with whom? _______________________

Has your work status changed because of this condition? Yes _____ No _____

If visit related to accident or injury, please specify: _____________________________________

Onset Date: ___________________________

Please list any medications you are currently taking:

Medication Dosage / # times per day For what? Date started

____

____

____

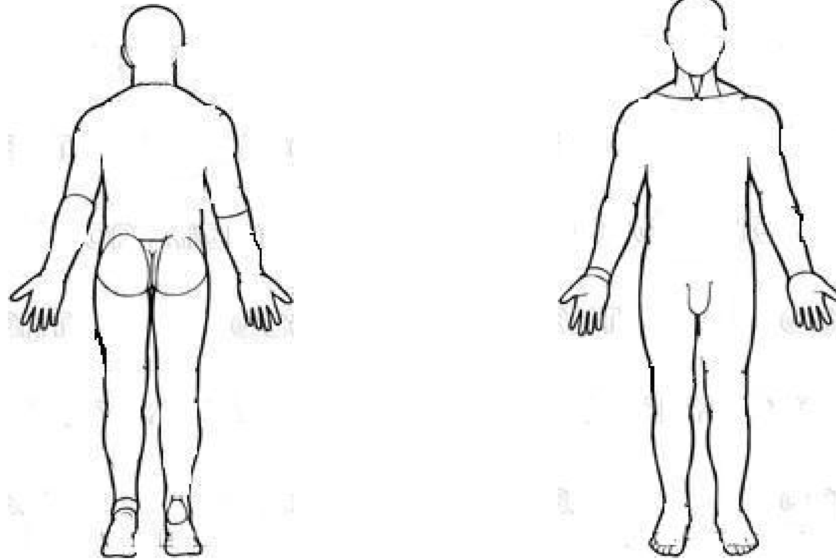
How would you rank your level of stress? High _____ Moderate _____ Low ______

How do you manage stress? ____

Are you currently following a special diet? Yes ______ No ______

Type of Diet: _______________

Please shade the areas that you have had symptoms:



How would you describe these symptoms? ____

Frequency of symptoms: Constant ______ **OR** Intermittent ______ How often: ____________________

Indicate the intensity of symptoms at their best:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Indicate the intensity of symptoms at their worst:
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

Symptoms are worse in the: ___Morning ___Afternoon ___Night
___Increased during the day ___Same all day

Past Medical History

Asthma/Bronchitis	_____	Headaches	_____
Shortness of Breath	_____	Vision difficulty	_____
Coronary Heart Disease	_____	Numbness/Tingling	_____
Do you have a pacemaker	_____	Dizziness/Fainting	_____
High Blood Pressure	_____	Weakness	_____
Heart Attack/Heart Surgery	_____	Weight/Energy Loss	_____
Blood Clot/Emboli	_____	Hernia	_____
Stroke/TIA	_____	Epilepsy/Seizures	_____
Allergies	_____	Thyroid issues	_____
Pins/Metal Implants	_____	Incontinence	_____
Joint Replacement	_____	Bowel/Bladder issues	_____
Diabetes	_____	Neck Injury	_____
Rheumatic Heart Disease	_____	Shoulder Injury	_____
Cancer/Chemotherapy	_____	Elbow/Hand Injury	_____
Arthritis	_____	Back Injury	_____
Osteoporosis	_____	Knee Injury	_____
Sleeping problems	_____	Leg/Ankle/Foot Injury	_____
Do you smoke	_____	Depression/Anxiety	_____
Parkinson's	_____	Chest discomfort	_____

FOR WOMEN ONLY: Please be certain to alert your team member immediately if you become pregnant.

Pelvic Inflammatory Disease	_____	Endometriosis	_____
Irregular Menstrual Cycle	_____	Pelvic Pain	_____
Complicated Pregnancies	_____	Are you pregnant?	_____

Any Other Health Issues?

____

____

Surgical History: ____

____

Family History:

Heart disease	______________________	Hypertension	______________________
Stroke	______________________	Diabetes	______________________
Cancer	____________________	Other	______________________

How would you rank your level of enjoyment of exercise?

High _____ Moderate ______Low ______

Are you currently involved in a regular exercise program? Yes ____ No _____

If yes, please list the activity and the frequency:

Activity	**Frequency**	**Equipment Used:**
_________________	_________________	_________________
_________________	_________________	_________________
_________________	_________________	_________________

Please check / list your health fitness goals:

- ☐ *Stay active and healthy*
- ☐ *Be able to travel actively*
- ☐ *Keep up with kids/grandkids*
- ☐ ____
- ☐ ____

Thank you for taking the time to complete this form.

CONSENT AND LIABILITY WAIVER

I authorize Fitness Matters, Inc. to perform physical therapy examinations, tests, and/or treatments that it considers necessary for my care. I agree to work with Fitness Matters, Inc. to maximize my progress towards mutually established treatment goals. I intend to be legally bound, authorizing Fitness Matters, Inc. and its representatives to share records and information with third parties participating in my rehab, including any party which an insurance program or otherwise is paying for all or part of my rehabilitation. I authorize Fitness Matters, Inc. to act on my behalf with any reasonable and necessary appeals in regards to services provided by Fitness Matters, Inc.

I authorize payment of medical benefits by any third party payer to be made directly to Fitness Matters, Inc. for any rehab services rendered to me. I, the patient, understand that I am financially responsible, as required by federal, state, and insurance company regulations, for any benefits not covered by a third party payer.

I acknowledge that I have been made aware of and fully understand that exercise and physical activity has the potential of resulting in personal injury. I acknowledge that I accept the risk of injury and waive any claims against Fitness Matters Inc. for any and all future injuries.

24-HOUR CANCELLATION NOTICE POLICY

Our AIM is to provide individual care via 1:1 appointments with highly skilled team members at an affordable cost. We have found that the only way we can achieve that AIM is with a 24-hour cancellation notice policy.

Fitness Matters is a system that includes you, our referring physicians, our team members – and even the community we serve. And, everything we do, including our policies, is directed towards a win for you, a win for others, and a win for us, too. For example, there is NEVER a hospital facility fee associated with your Physical Therapy visits at Fitness Matters, making each visit more affordable.

Cancellations without 24 hours' notice can result in a cancellation fee of $65.

Thank you for understanding and for being a part of our system,

The Fitness Matters Team

I have read the consent and late cancellation policy and agree to comply with the terms described.

____

Signature (Guardian if minor) **Date**

____

Print