****

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

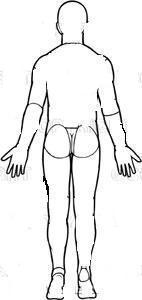
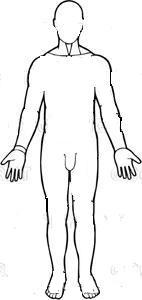
How would you rank your level of stress?High \_\_\_\_\_ Moderate \_\_\_\_\_ Low \_\_\_\_\_\_

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**