



Physical Therapy • Pilates • Fitness

TODAY'S DATE: \_\_\_\_\_

**CONTACT INFORMATION**

PATIENT/CLIENT LAST NAME: \_\_\_\_\_ FIRST NAME : \_\_\_\_\_ M.I. \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ AGE \_\_\_\_\_ GENDER: \_\_\_\_\_ MARITAL STATUS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_ RELATIONSHIP TO YOU: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ CELL PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

**CONSENT TO TREATMENT**

I hereby voluntarily consent to treatment at my own discretion or as prescribed by a physician, his/her assistant(s), consultant(s), appropriate licensed health care professional and provided by Complete Body Wellness Studio, LLC's therapists, assistants, employees, agents or representatives. I acknowledge my responsibility for discussing and understanding my proposed treatment plan and goals based on the evaluation with my practitioner, as well as expected benefits or potential risks and drawbacks of the treatment or procedure utilized in my care and that treatment does not guarantee an improvement in my current condition.

Treatment and procedure may include, but not conclusive of, hands on/manual therapy techniques, bone and soft tissue manipulation, myofascial release, deep tissue massage, joint mobilization, therapeutic exercise and stretching programs, Pilates exercise, neuro-muscular re-education, gait training, trigger point dry needling, manual traction, ultrasound, laser, electrical stimulation, bio-feedback, hot and cold packs or other treatment modalities. I authorize the fully trained staff at Complete Body Wellness Studio, LLC to use these treatment techniques as deemed necessary for my safe and effective recovery.

**I have read Complete Body Wellness Studio, LLC's Consent to Treatment and agree to all terms and conditions.**

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Signature of Patient/Client/Parent/Legal Guardian

# Physical Therapy Patient Questionnaire



Today's Date: \_\_\_\_\_  
Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_

Gender: **M F** Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Do you smoke?: **No Yes** \_\_\_\_\_ Packs/day Do you drink caffeinated beverages?: **No Yes** \_\_\_\_\_ cups/day  
Women: Are you currently pregnant or think you might be pregnant: **No Yes** Due Date: \_\_\_\_\_  
Do you have a pacemaker or any surgically placed device: **No Yes**

Are you currently working?: **No Yes** If so, what is your occupation?: \_\_\_\_\_  
Are you on a work restriction from you doctor?: **No Yes**  
Describe your regular exercise routine: \_\_\_\_\_  
Hobbies that you enjoy or would like to get back to doing \_\_\_\_\_  
During the past month, have you been feeling down, depressed or hopeless: **No Yes**  
During the past month, have you had little interest or pleasure in doing things?: **No Yes**  
If yes, is this something with which you would like help?: **No Yes, but not today Yes**

Please list all current medications: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 (or see attached ) \_\_\_\_\_  
Do you currently take blood thinners or anticoagulants?: **No Yes** Are you allergic to latex?: **No Yes**

Past Surgical History (include dates): \_\_\_\_\_  
List any x-ray, MRI or other imaging study you've had in the past (include dates): \_\_\_\_\_  
Have you had a recent illness?: **No Yes** (if yes, please explain): \_\_\_\_\_

- Have you RECENTLY noted any of the following? (check all that apply):**
- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Changes in appetite            | <input type="checkbox"/> Dizziness/lightheadedness | <input type="checkbox"/> Pain at night       |
| <input type="checkbox"/> Changes in bowel or bladder    | <input type="checkbox"/> Fever/chills/sweats       | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Difficulty maintaining balance | <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Weakness/fatigue    |
| <input type="checkbox"/> Difficulty swallowing          | <input type="checkbox"/> Nausea/vomiting           | <input type="checkbox"/> Weight loss/gain    |

- Have you EVER been diagnosed with any of the following conditions? (check all that apply)**
- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Heart disease         | <input type="checkbox"/> Rheumatoid arthritis     |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Angina/chest pain     | <input type="checkbox"/> Parkinson's disease      |
| <input type="checkbox"/> Cancer (type) _____ | <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Lung disease          | <input type="checkbox"/> Stomach ulcers           |
| <input type="checkbox"/> Depression          | <input type="checkbox"/> Multiple sclerosis    | <input type="checkbox"/> Thyroid problems         |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Kidney/liver disease     |
| <input type="checkbox"/> Epilepsy/seizures   | <input type="checkbox"/> Osteoarthritis        | <input type="checkbox"/> History of alcohol abuse |
| <input type="checkbox"/> Blood clots         | <input type="checkbox"/> History of drug abuse | <input type="checkbox"/> Fibromyalgia             |

**Patient Name:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_ **Date of next Doctor's visit:** \_\_\_\_\_

What date (approximately) did your present pain start? \_\_\_\_\_ Was it a sudden injury or a gradual onset? \_\_\_\_\_

Have you ever had this problem before? **YES / NO** If so, how was the problem treated? \_\_\_\_\_

Have you had a related surgery? **YES / NO** Have you received any treatment for this problem before today? \_\_\_\_\_

If you had this problem before and received treatment, how long did it take you to feel better? \_\_\_\_\_

My current symptoms are: **Getting better / Staying the same / Getting worse**

Are your symptoms worse in the: **Morning / Afternoon / Evening / Other** \_\_\_\_\_

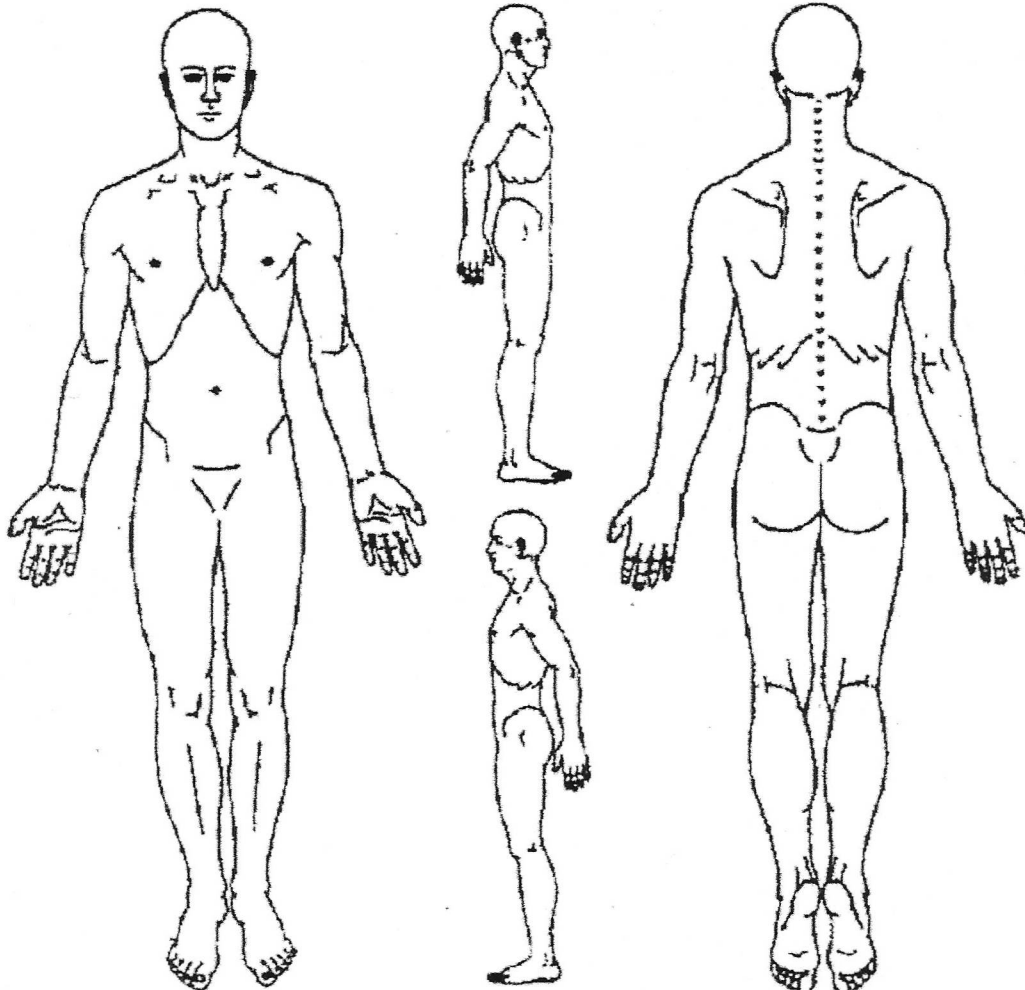
How are you able to sleep at night? **Fine / With moderate difficulty / Only with medication / Other** \_\_\_\_\_

What makes your symptoms / pain worse? \_\_\_\_\_

What makes your symptoms / pain better? \_\_\_\_\_

### Body Pain Chart

On this body chart, please mark the location of your pain and the type of pain using the appropriate symbols from the key below. Where are you currently having symptoms? \_\_\_\_\_



#### KEY

Numbness/Tingling	XXXXX
Pins and Needles	^^^^^
Dull Ache	00000
Burning	/////
Stabbing	>>>>
Severe Pain	SSSSS

For the injury you are seeing us for today:

Current Pain	0	1	2	3	4	5	6	7	8	9	10
Best in 48 hours	0	1	2	3	4	5	6	7	8	9	10
Worst in 48 hours	0	1	2	3	4	5	6	7	8	9	10
No Pain											
Worst Pain Imaginable											

**INSURANCE INFORMATION**

**PRIMARY INSURANCE COMPANY:**

Carrier \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip code \_\_\_\_\_ Phone \_\_\_\_\_  
Policy ID Number \_\_\_\_\_ Group \_\_\_\_\_  
Name of the Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security number \_\_\_\_\_ Sex M F  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**SECONDARY INSURANCE COMPANY:**

Carrier \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip code \_\_\_\_\_ Phone \_\_\_\_\_  
Policy ID Number \_\_\_\_\_ Group \_\_\_\_\_  
Name of the Policy Holder \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Sex M F  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_

**WORKMAN'S COMPENSATION INSURANCE:**

Carrier \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip code \_\_\_\_\_ Phone \_\_\_\_\_  
Claim Number \_\_\_\_\_ Case Worker's Name \_\_\_\_\_  
Case Worker's Phone Number \_\_\_\_\_ Fax \_\_\_\_\_  
Employer at time of injury \_\_\_\_\_  
Address \_\_\_\_\_

**ASSIGNMENT OF BENEFITS:**

Your signature is necessary for us to process any insurance claims and to ensure payment of services rendered. I authorize release of all medical information necessary to process my insurance claims or that is pertinent to my medical care. I assign all medical and/or surgical benefits, including major medical benefits to which I am entitled to the above named physician or clinic. This agreement will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTAND IT.

Patient \_\_\_\_\_ Date \_\_\_\_\_

Responsible Party \_\_\_\_\_ Date \_\_\_\_\_