COACHING FITNESS
FUSION atl
PHYSICAL THERAPY

(For office use only) *Today's Date*:_____

BP: _____/_____
Pulse: _____
Height/Weight _____
Falls _____

Patient Information Form

Name & Address

Last_____ First _____MI _____

Street _____City_____ State_____ Zip_____

Date of Birth: _____ Age :_____ Gender:_____

Primary Phone: _____**(Cell, Home)** Secondary Phone: _____(Cell, Home)

Email: _____

Do you wish to receive appointment reminders by: ____text ____email

Emergency Contact

Last_____ First_____MI_____

Primary Phone:_____ **(Cell, Home, Work) Relationship**_____

If Patient is a minor - Name of Parent or Guardian

Last_____First_____Phone:_____ (Cell, Home, Work)

Referring Physician

Name_____Office Phone_____ Office Fax_____

Address _____

City_____ State_____ Zip _____

Primary Care Physician

Name_____Office Phone_____Office Fax_____

Address _____

City_____ State_____ Zip _____

Patient's Name: _____ ***Today's Date*:**_____

Insurance Information (if applicable)

Primary Insurance

Company_____Deductible_____

ID_____ Group#_____

Subscriber Name_____Relationship _____

Subscriber DOB _____

Secondary Insurance

Company_____

ID_____ Group#_____

Subscriber Name_____Relationship_____

Subscriber DOB _____

Employment Information

Work status

____ Full time _____Part time _____Retired ____Unemployed ____Regular duty ____Restricted duty

Employer's Name: _____ Occupation _____

Address: _____City:_____State_____ Zip _____

Personal Information – Lifestyle

Height:_____Weight _____

Have you had any falls in the past year? ____ *If yes, how many?* _____

Would you consider yourself: _____Physically active _____Sedentary

What is your current exercise routine? _____

What activities do you wish to return to?_____

Patient's Name: _____ ***Today's Date*:**_____

Injury Information

Where is your pain located? _____How long have you had these symptoms?_____

Cause of Injury - Check all that apply

____Chronic symptoms ____Motor vehicle accident ____Sports/recreational ____Work related ____Overuse ____Trauma
____Unknown ____Other _____

Diagnostic Testing

____NCV/EMG ____Bone scan ____Cardiac stress test ____Doppler ____Urinalysis ____CT Scan ____Blood test
____MRI ____Ultrasound ____X-ray Results _____

Prior Treatment – Check ALL that apply

____Acupuncture ____Chiropractic ____Massage ____Rest ____Physical Therapy ____Injection
____Medication ____Other _____
____Surgery Date of surgery_____

My symptoms are RELIEVED by - Check ALL that apply

____Modifying activity ____Stopping activity ____Lying down ____Medication ____Heat ____Standing ____Ice
____Rest ____Sitting ____Walking

My symptoms are AGGRAVATED by – Check ALL that apply

____Modifying activity ____Stopping activity ____Lying down ____Medication ____Standing ____Heat ____Ice
____Rest ____Sitting ____Walking

Medical History ***List of Medical Conditions and Diseases – Check ALL that apply***

____Allergies ____Asthma ____Arthritis ____Cancer ____Cardiac conditions ____ Pacemaker
____ Pregnant ____Anxiety ____Depression ____Diabetes ____Dizzy spells ____Lung problems
____Fractures ____Kidney ____Metal implants ____Seizures ____Parkinson's ____Osteoporosis
____Strokes ____Vision ____Thyroid ____Ulcers ____Weight loss ____Tuberculosis
____Incontinence ____Multiple sclerosis ____Circulation problems ____Gallbladder problems
____High blood pressure ____Rheumatoid arthritis

Describe any other conditions or precautions

Surgical history: Surgery type _____Date of surgery_____

Current medication(s) (use another page if needed)

Name	Dosage	Frequency/route of administration

Physical Therapist Signature _____ **Date**_____

(***7/2015***)