New Client Information

Personal Information

Name _____ Gender _____

Address _____

Phone _____ Email _____

DOB _____ Referred by _____

Emergency Contact Name and Phone Number _____

History

How often do you exercise?

What types of exercise do you perform?

Pregnant? _____ Pacemaker? _____ Allergies _____

What medications are you currently taking? _____

Surgeries, injuries, or conditions _____

Current Needs

What brings you here today? _____

Do you know what caused it? _____

Symptoms _____

When did these symptoms begin? _____

What seems to make your symptoms worse? _____

What, if anything, brings relief? _____

What is the worst time of day for your symptoms? _____

Is there a time of day when your symptoms are less intense? _____

Have you seen a doctor for these symptoms? _____

What treatments have you tried already? _____

Current intensity of pain [ ] Intermittent [ ] Constant [ ] Only with certain motions

Current frequency of pain [ ] Mild [ ] Moderate [ ] Severe [ ] Excruciating

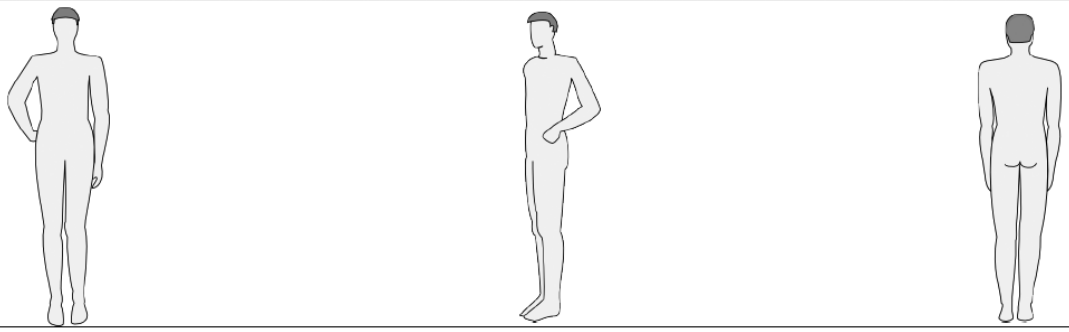
Overall, does your pain seem to be getting better or worse? _____

SARA RUVINSKY
physical therapy

Do any of the following conditions apply to you today? (Check all that apply)

[ ] AIDS/HIV
[ ] Anemia
[ ] Angina
[ ] Arteriosclerosis
[ ] Arthritis
[ ] Asthma
[ ] Blood Clots
[ ] Bone Infection
[ ] Cancer
[ ] Chemical Dependency
[ ] Circulation Problems
[ ] Depression
[ ] Diabetes
[ ] Epilepsy
[ ] Eye Infection
[ ] Heart Problems
[ ] Hemophilia
[ ] High/Low Blood Pressure
[ ] Joint Infection
[ ] Liver Problems
[ ] Lung Issues
[ ] Multiple Sclerosis
[ ] Musculoskeletal Problems
[ ] Pneumonia
[ ] Stroke
[ ] STD
[ ] Tuberculosis
[ ] Urinary Infection

Mark your current areas of discomfort:



Signature _____ Date _____