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# Welcome to NeuroFit Wellness & Physical Therapy!

## Client Information:

First Name:_____Last Name:_____Middle Initial:_____

Street Address:_____Apt #:_____

City:_____State:_____Zip Code:_____

Cell Phone:_____ Home Phone:_____

E-mail Address:_____ Work Phone:_____

Preferred Contact: □ Home phone / □ Cell Phone / □ Work Phone / □ Email (check one)

DOB (mm/dd/year): _____ Gender: □ Male □ Female

Person to Notify in Emergency:_____

Relationship:_____Phone #: (_____)_____

## Who Can We Thank?

*How did you hear about NeuroFit Wellness & Physical Therapy (please check one)?*

□ NeuroFit Family/Friend (please provide name):_____*May we thank them?* □ Yes □ No
□ Healthcare Provider (please provide name):_____*May we thank them?* □ Yes □ No
□ Online (Google/Facebook/NeuroFit Website/Etc.)
□ Healthy Beginnings Magazine
□ N2 Magazine
□ Television
□ Other (please list):_____

## Medical History

*Please describe the current problem that brought you here?*

_____

_____

*When did your problem first begin?*

_____

_____

*Was your first episode of the problem related to a specific incident?* □ Yes □ No, If yes, please briefly describe:

_____

_____

*Since that time has the problem has:* □ stayed the same □ gotten worse □ gotten better

*Rate the severity of this problem from 0 -10 (0 is no pain at all and 10 being the worst pain imaginable):*

Currently _____ At its Best _____ At its Worst _____

*What makes it better:*

_____

*What makes it worse:*

_____

*Describe the nature of the pain (i.e. constant, intermittent, burning, sharp, dull, ache):*_____

*Has this problem affected your daily life or routine? Briefly describe in what ways.*

_____

_____

*Have you had past similar episodes of this current problem? If yes, were you treated with (check disciplines which apply):*

□ Physical Therapy □ Acupuncture □ Chiropractor

□ M.D. (Meds, TPI's) □ Massage Therapist □ Pilates

□ Self medicated (advil) □ Ignored it □ General Exercise/exercise with trainer

□ Other:_____

*Did they help to alleviate your symptoms? If yes, please describe helpful treatments.*

_____

_____

*Have you undergone any special tests for this condition? (X-rays, MRI's, EMG, Cystoscopy, Urodynamics, Etc.) If yes, please provide a brief explanation of the results.*

_____

_____

_____

_____

*How would you describe your general health (check one):* □ Excellent □ Good □ Average □ Fair □ Poor

*What is your currently activity/exercise level:* □ None □ 1-2 days/week □ 3-4 days/week □ 5+ days/week

*Have you fallen in the past year?* □ Yes □ No

*If yes, how many times in the past year:* _____ *In the past 2 years:* _____

*Has a fall resulted in an injury?* □ Yes □ No *If yes, please describe your injury:*

_____

_____

*Height* _____ *Weight* _____

*Current Tobacco Usage* □ Yes □ No *If yes, what type and list your daily usage/frequency?* _____

*Current Alcohol Usage* □ Yes □ No *If yes, list your daily usage/frequency?* _____

*Has any of your medication changed recently?* □ Yes □ No

*Please list your current medications and/or supplements* (over the counter/prescription). Please include dosage and reason for taking.

_____

_____

*Please answer the following questions:*

| | |
|---|---|
| Do the current problems interrupt your sleep? | □ Yes □ No |
| Do your symptoms change with coughing or sneezing? | □ Yes □ No |
| Have you had any recent changes in bowel or bladder function? | □ Yes □ No |
| Do you experience any dizziness or vertigo? | □ Yes □ No |
| Have you had any recent change in your weight or appetite? | □ Yes □ No |
| Do you have any intolerance to hot or cold? | □ Yes □ No |
| Do you have any bruising or bleeding disorders? | □ Yes □ No |
| Have you had any skin changes, such as rashes or discoloration? | □ Yes □ No |
| Have you experienced any changes in your vision (i.e. blurring or double vision) | □ Yes □ No |
| Are you pregnant? | □ Yes □ No |
| Have you had a recent episode of nausea/vomiting? | □ Yes □ No |
| Do you have osteoporosis? Date of your last bone scan:_____ | □ Yes □ No |
| Have you noticed any shortness of breath or decrease in exercise tolerance? | □ Yes □ No |
| Do you use any assistive device? (cane foot orthotics) | □ Yes □ No |

*Have you ever had any of the following conditions or diagnoses? (please check all that apply)*

| | | | | |
|---|---|---|---|---|
| □ Cancer | □ Acid Reflux | □ Fibromyalgia | □ Vision/eye problems | □ Childhood bladder problems |
| □ Heart Problems | □ Belching | □ Headaches | □ Arthritic condition | □ Irritable Bowel Syndrome |
| □ Emphysema/ chronic bronchitis | □ Ankle Swelling | □ Hearing loss/problems | □ Bone fracture | □ Pelvic Pain |
| □ Epilepsy/seizures | □ Alcoholism/Drug problems | □ Hypothyroid | □ Joint Replacement | □ Physical or Sexual abuse |
| □ Head Injury | □ Allergies (list below) | □ Hyperthyroid | □ Low Back Pain | □ Sacroiliac/Tailbone pain |
| □ High Blood Pressure | □ Anemia | □ Latex Sensitivity | □ Osteoporosis | □ Sexually transmitted disease |
| □ Multiple Sclerosis | □ Chronic Fatigue Syndrome | □ Kidney disease | □ Sports Injuries | |
| □ Stroke | □ Depression/anxiety | □ Hepatitis | □ Stress fracture | |
| □ Diabetes | □ Anorexia/bulimia | □ Raynaud's | □ TMJ/neck pain | |
| | | □ Smoking history | | |

Other: _____

*Any other illness, past injuries I should be aware of?*_____

*Past surgeries___yes, ___no.  If yes, please give brief details:*_____

_____

_____

*Please list two goals that you would like to accomplish with NeuroFit Wellness & Physical Therapy.*

1._____

2._____