ActiveEDGE
PHYSICAL THERAPY

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Thank you for choosing Active Edge Physical Therapy & Sports Medicine! To best serve you, we require the following information. Please print clearly. All information **will be** *confidential.*

PATIENT INFORMATION

PATIENT NAME: _____ DATE OF BIRTH: _____

❍ Male ❍ Female | ❍ Single ❍ Married ❍ Minor ❍ Other: _____ | ❍ Employed ❍ Full Time Student ❍ Part Time Student ❍ Other: _____

PRIMARY PHONE: _____ EMAIL: _____

Ok to leave Message? ❍ Yes ❍ No *How would you like to receive appointment reminders?* ❍ Email ❍ Text ❍ Phone

RESPONSIBLE PARTY: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

RELATIONSHIP: _____

PRIMARY INSURANCE POLICY HOLDER

NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____

SECONDARY INSURANCE POLICY HOLDER

NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP: _____

COMPLAINT OR INJURY

CHIEF COMPLAINT: _____ *(body part)* DATE OF ONSET: _____

DATE LAST SEEN BY PHYSICIAN: _____

DESCRIPTION OF INJURY: _____

MEDICATIONS: _____

_____

(List all prescription and nonprescription.)

PREVIOUS SURGERY / HOSPITALIZATION: _____

_____

(Please note date of surgery/hospitalization.)

CURRENT CONDITION

Please Check any problems you have had in the past 12 months.

- ❍ Recent Single Fall
- ❍ Recent Multiple Falls
- ❍ Wheezing
- ❍ Fever/Sweats/Chills
- ❍ Migraine Headaches
- ❍ Excessive Fatigue
- ❍ Blackouts
- ❍ Smoking
- ❍ Swelling of Joints
- ❍ Muscle Pain/ Cramps
- ❍ Numbness or Tingling
- ❍ Weight Loss or Gain
- ❍ Loss of Appetite
- ❍ Difficulty Walking
- ❍ Eyes/Vision
- ❍ Ears/Hearing
- ❍ Nose/Mouth/Throat
- ❍ Skin Rash
- ❍ Infections
- ❍ Bleeding/Bruising
- ❍ Gland/Hormones
- ❍ Nervousness/Anxiety
- ❍ Sexual Difficulty
- ❍ Difficulty Sleeping
- ❍ Male-Prostate
- ❍ Female-Menstrual
- ❍ Alcohol

EXISTING/RELEVANT CONDITIONS

❍ Other Conditions: _____

_____

MEDICAL HISTORY

Please check if you ever have had the following.

- ❍ Allergies
- ❍ Anemia
- ❍ Anxiety
- ❍ Arthritis
- ❍ Asthma
- ❍ Cancer
- ❍ Cardiac Condition
- ❍ Depression
- ❍ Diabetes
- ❍ Dizzy Spells
- ❍ Emphysema/Bronchitis
- ❍ Fractures
- ❍ Gallbladder Problems
- ❍ Hepatitis
- ❍ High Blood Pressure
- ❍ Incontinence
- ❍ Kidney Problems
- ❍ Metal Implants
- ❍ Multiple Sclerosis
- ❍ Osteoporosis
- ❍ Parkinsons
- ❍ Rheumatoid Arthritis
- ❍ Seizures
- ❍ Speech Problems
- ❍ Strokes
- ❍ Thyroid Disease
- ❍ Tuberculosis
- ❍ Vision Problems

HOW DID YOU HEAR OF US?

❍ Doctor Referral ❍ Online research ❍ Drive by ❍ Other: _____

❍ Family/Friend Name: _____ They recommended therapist _____

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Active Edge Physical Therapy to furnish medical care and treatment to me (or my child) considered necessary and proper in diagnosing or treating my (or his/her) condition.

_____ PATIENT OR GUARDIAN *(print)*

_____ PATIENT OR GUARDIAN *(signature)*

_____ DATE