SportsFit
Physical Therapy & Fitness

First Name _____ Last Name _____

Date of Birth _____ Age _____ Social Security: _____-_____-_____ Sex: M F

Email: _____ Referred By:_____

Home Phone: ( ) _____-_____ Work/Cell Phone: ( ) _____-_____

Address _____

City _____ State _____ Zip _____

Occupation: _____Employer: _____

Sports/Activities:_____

Injury Area: _____ Date of injury/onset _____ Accident Related? Y N

Emergency Contact _____Phone: ( ) _____-_____

Are you receiving or have you recently received home health services? Yes No
Are you receiving or have you received other therapy services? Yes No

	Yes	No
Recent trauma (MVA, FALL) ----------	☐	☐
Recent blow to head ----------	☐	☐
Recent whiplash injury ----------	☐	☐
Recent weight loss/gain ----------	☐	☐
Recent surgery ----------	☐	☐
Recent initiation of exercise program --	☐	☐
Recent Injection(s) ----------	☐	☐
Changes in bowel/bladder control ------	☐	☐
Osteoporosis ----------	☐	☐
Immunosuppressive disorder ----------	☐	☐
Rheumatoid arthritis ----------	☐	☐
Currently on Antibiotics ----------	☐	☐
Heart problems ----------	☐	☐
Diabetes ----------	☐	☐
Hypertension ----------	☐	☐
History of Cancer ----------	☐	☐

	Yes	No
Fever, chills, and or night-sweats----------	☐	☐
Numbness in “saddle” area ----------	☐	☐
Weakness ----------	☐	☐
Numbness/tingling in your arms/legs -----	☐	☐
Corticosteroid therapy/medication --------	☐	☐
Do you smoke ----------	☐	☐
Difficulty breathing, coughing, sneezing -	☐	☐
Difficulty speaking ----------	☐	☐
Clumsiness/weakness in arms or legs -----	☐	☐
Headaches ----------	☐	☐
Difficulty concentrating ----------	☐	☐
Dizziness ----------	☐	☐
Changes in vision ----------	☐	☐
Nausea/vomiting ----------	☐	☐
Sensitivity to light /sound ----------	☐	☐
Increased pain during menstrual cycles --	☐	☐

Please list any other major medical conditions not listed above:

_____

_____

_____

Please List your medications:

_____

_____

In addition to physical therapy, what other services are you interested in: (Please check all that apply)
Massage Therapy ☐ Pilates ☐ Yoga Therapy ☐ Personal Training ☐ Acupuncture ☐

What's your preferred method of appointment reminders? Text Message ☐ Email ☐

Wireless Carrier:_____

How did you find SportsFit:

Physician Referral: ☐ Name:_____
Friend/Family Referral: ☐ Name:_____
Internet: ☐ Site:_____
Other: ☐ _____

Please initial after reading statements:

1. Consent to Treatment: I consent to rehabilitation and related services at SportsFit Physical Therapy Corporation. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. _____

2. Liability: I know and agree that SportsFit Physical Therapy Corporation is not responsible for loss or damage to personal valuables. _____

3. Authorization of Payment: I hereby assign all benefits directly to SportsFit Physical Therapy Corporation and authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I received, I will be financially responsible for payment. _____

4. Cancellation Policy*: Unless there is a medical emergency, same day cancellations are not accepted for scheduled appointments. Same day cancellations and/or no shows will be charged a fee of $75 per session. _____

5. Treatment of Minor: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

**See our "Appointment & Payment Agreement Form" for details.*

Patient Signature: _____Date: _____