



First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_', \_\_\_\_" 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 If Yes, Select MVA  Fall  Sports Related  Worker's Compensation

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		Yes	No
Recent trauma or accident-----	<input type="checkbox"/>	<input type="checkbox"/>	Fever, chills, and or night-sweats-----	<input type="checkbox"/>	<input type="checkbox"/>
Recent Falls (last 2 years) -----	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in "saddle" area -----	<input type="checkbox"/>	<input type="checkbox"/>
Recent blow to head -----	<input type="checkbox"/>	<input type="checkbox"/>	Weakness -----	<input type="checkbox"/>	<input type="checkbox"/>
Recent whiplash injury -----	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling in your arms/legs ----	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight loss/gain -----	<input type="checkbox"/>	<input type="checkbox"/>	Corticosteroid therapy/medication -----	<input type="checkbox"/>	<input type="checkbox"/>
Recent surgery -----	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke -----	<input type="checkbox"/>	<input type="checkbox"/>
Recent initiation of exercise program --	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing, coughing, sneezing -	<input type="checkbox"/>	<input type="checkbox"/>
Recent Injection(s) -----	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty speaking -----	<input type="checkbox"/>	<input type="checkbox"/>
Changes in bowel/bladder control -----	<input type="checkbox"/>	<input type="checkbox"/>	Clumsiness/weakness in arms or legs ----	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis -----	<input type="checkbox"/>	<input type="checkbox"/>	Headaches -----	<input type="checkbox"/>	<input type="checkbox"/>
Immunosuppressive disorder -----	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty concentrating -----	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis -----	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness -----	<input type="checkbox"/>	<input type="checkbox"/>
Currently on Antibiotics -----	<input type="checkbox"/>	<input type="checkbox"/>	Changes in vision -----	<input type="checkbox"/>	<input type="checkbox"/>
Heart problems -----	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting -----	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes -----	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to light /sound -----	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension -----	<input type="checkbox"/>	<input type="checkbox"/>	History of Cancer -----	<input type="checkbox"/>	<input type="checkbox"/>



Please list any other major medical conditions not listed above:

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Please List your medications:

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In addition to physical therapy, what other services are you interested in: (Please check all that apply)

Massage Therapy  Pilates  Yoga Therapy  Personal Training  Sports Medicine

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: \_\_\_\_\_