

New Client Questionnaire

Please Print Clearly

Date: _____

Name: Last First M

Occupation: Employer: Work ph:

Home Address: Street apt City: zip code:

Home Phone: Cell: Email address:

Social Security # Birth Date: Age: _/ _

Summer Sports? Winter Sports? Primary sport?

Snow/Wake Boarders _ Regular or Goofy?

Goals: 1. Gym Member? Name
2. _____

Injury/Surgery History _

Currently taking medications? Yes/No

Name or type of medication _

Do you have or ever had any of the following?

<input type="checkbox"/> Blood Pressure Problems	<input type="checkbox"/> Asthma	<input type="checkbox"/> Fainting/loss of consciousness	<input type="checkbox"/> any condition which may affect training/rehab?
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Easily Bleed or Bruise	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Circulatory Problems/Clots	<input type="checkbox"/> Allergies (please list):	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Leg/Ankle Swelling		

Emergency Contact _ Ph#

Payment (self-pay) Check Cash

Options:

Credit Card: Master Card/Visa AmEx Credit card # Exp date:

Credit card authorization Signature

How did you hear about action sports medicine?

Please ensure that you complete & sign the appropriate forms:

Training Clients:

Page 1 of New Client Questionnaire
 Liability Form(s)
 Policy & Procedure Form

Rehabilitation Clients:

Page 1&2 of New Client Questionnaire
 Policy & Procedure Form
 Download or request Privacy Practice Act

Signature (legal guardian if under 18years old)

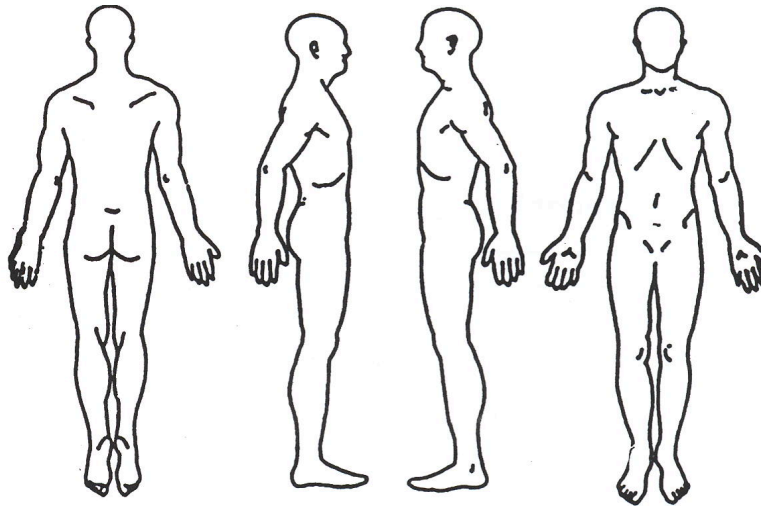
Print

Date

New Client Form [page 2] for Physical Therapy

Name: _____ Date: _____ Date of Injury/Surgery: _____ Insurance Carrier: _____ Phone # _____ for providers: _____ ID# _____ Group # _____	Referring Physician: _____ Physician Medical Group (if applicable) Did this occur at work? Yes/no _____ Name of Insured: _____ Relationship to insured: _____
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Please mark the area(s) of concern:
 P1: primary region
 P2: secondary region



Type of Pain:
 _aching _sharp _pressure _tingling _numbness _dull _pressure _tightness

Rate your Pain: (0= no pain _ 10 = emergency room admittance) circle the appropriate number below

Current Level: 0 1 2 3 4 5 6 7 8 9 10

At its Best: 0 1 2 3 4 5 6 7 8 9 10

At its worst: 0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms worse? _____

What makes your symptoms better? _____

What activities are you unable to participate in? _____

What do you hope to get out of your therapy besides alleviation of your pain? _____

Questions or Comments you would like to include: _____

Signature (legal guardian if under 18 years old) _____ Print _____ Date _____

*** please ensure that forms listed on page 1 are also completed & signed along with this 2 page questionnaire**