Confidential Patient Information

Patient Contact Information

First Name: _____Last Name:_____

Address: _____City:_____ST:_____Zip:_____

Phone: (_____)_____Cell Phone(_____)_____ Birth Date: _____/_____/_____

EMAIL:_____ Gender: M/F Age:_____ Height: _____ Weight: _____

Date: _____ Emergency Contact Name: _____Phone:_____Relation: _____

How did you first hear about us?
[ ] Physician: _____ [ ] Friend/Family: _____ [ ] Internet _____ [ ] Advertisement _____

Health History

Please read each question carefully. Initial in the space provided indicating that you understand what is recommended. Physical activity should not be hazardous for most people. The questions are designed to identify those who should consult a physician prior to beginning a program of physical exercise.

	Yes	No
1. Has a doctor ever said you have a heart condition and recommended medically supervised physical activity?	[ ]	[ ]
2. Do you have chest pain brought on by physical activity?	[ ]	[ ]
3. Do you tend to lose consciousness, feel faint or have spells of dizziness?	[ ]	[ ]
4. Has your doctor recommended medication for blood pressure?	[ ]	[ ]
5. Have you ever had surgery?	[ ]	[ ]

Please list any surgeries (include dates):

6. Has a doctor ever told you that you have a bone or joint problem(s), such as arthritis that might be made worse with exercise?	[ ]	[ ]

Explain:

7. Are you aware, through your own experiences or a doctor's advice, of any other physical reason against your exercising without medical supervision?	[ ]	[ ]

Explain:

Please Check all conditions that apply to you:

~ Heart Disease or Stroke	~ Prostate Disease	~ Gallbladder Disease	~ Monitored by Physician
~ High Blood Pressure	~ Depression	~ Low-back pain in last 6 months	~ Recommended High-Level Care
~ High Triglycerides	~ Diabetes Mellitus	~ Psychological Problems	
~ Cancer	~ Obesity	~ Anorexia	~ Special Diet
~ Lung/Pulmonary Disease	~ Arthritis	~ Bulimia	~ Other Medical Conditions
~ Kidney Disease	~ Anemia	~ Compulsive Overeating	
~ Osteoporosis	~ Food Allergies	~ Pregnant/Lactating/ Trying to	
~ Ulcer	~ Neuromuscular Disease		
~ Gastrointestinal Disease	~ Arteriosclerosis		

If you answered YES to one or more of the questions above, please answer and initial the following questions:

Please list any medications you are currently taking below:

Lifestyle Questions

Do you:

Eat 3-5 Meals Per Day: **YES** **NO**

Drink Adequate Water **YES** **NO**

How many ounces per day? _____

Do you eat **5 servings** of Fruits/Veggies a Day? **Yes** **No**

Do you Take Daily Vitamins: **YES** **NO**

Or Supplements: _____ **YES** **NO**

Get 7+ Hrs. of Sleep Daily: **YES** **NO**

Do you Eat Fast Food: **Yes** **No**

How many times per week? _____

Drink Alcohol: **YES** **NO**

Eat Restaurant Food: **YES** **NO**

How many times per week? _____

Drink Coffee: **YES** **NO**

Smoke: **YES** **NO**

Eat Healthy Snacks: **YES** **NO**

Eat Sugary Snacks: **YES** **NO**

Drink Soft Drinks **YES** **NO**

How many per day? _____

Watch TV/Sit at Computer: **YES** **NO**

How many hrs of sitting per day?_____

Describe your Hobbies: What do you like to do for Fun?

Current Symptom Checklist

What is your chief complaint and any symptoms related to this?

What have you previously done regarding care for this complaint? *(Physical therapy, meds, exercise, surgery, etc)*

Have you ever participated in a physical therapy program for this complaint?

❑ Yes ❑ No If so, describe:

Did you get results? ❑ Yes ❑ No Describe:

What was your reason for not continuing with the previous care plan?

When did you first start having these symptoms? Do you recall what the injury or accident entailed?

Have you ever had any re-occurring injuries/pain in this same area of the body?

Explain:

What do you do for your job? *(sit, stand, drive, walk, lift, etc)*

How many hours per week do you work in that setting?

What would you like to get out of working with the Sports Medicine Specialists at Efficient Movement?

Rate your Motivation

1 2 3 4 5 6 7 8 9 10

PAYMENT AND INSURANCE INFORMATION

Efficient Movement (EMovement, LLC) is a private pay health care business. We are not contracted with any third-party health insurance companies. I understand and agree that health insurance policies are an arrangement between an insurance company and me as the patient, directly. I hereby authorize the undersigned medical providers to furnish medical information to my insurance carriers concerning this injury or illness, if applicable. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

PATIENT SIGNATURE _____ Date _____

PARENT/GUARDIAN'S SIGNATURE IF PATIENT IS UNDER AGE 18_____

PATIENT'S ACKNOWLEDGEMENT AND ASSUMPTION OF RISK AND FULL RELEASE FROM LIABILITY OF EFFICIENT MOVEMENT

Patient acknowledges that the therapy and fitness assessment hereunder may include participation in strenuous physical activities, including but not limited to, flexibility movements, aerobic movement, weight training, and various nutritional programs offered by EFFICIENT MOVEMENT. Patient agrees to assume all risk and responsibility involved with participation in the physical activities. Patient affirms that he/she is in good physical condition and does not suffer from any disability that would prevent or limit participation in physical activities. Member acknowledges that participation will be physically and mentally challenging, and member agrees that it is the responsibility of the member to seek competent medical or other professional advice, regarding any concerns involved with the ability of patient to take part in EFFICIENT MOVEMENT physical activities. Member agrees to assume all risks in responsibility for not exceeding his/her physical limits.

PATIENT SIGNATURE _____ Date _____

PARENT/GUARDIAN'S SIGNATURE IF PATIENT IS UNDER AGE 18_____