



For office use only:

ICD9 Code(s)

Welcome to Athletes' Training Center and thank you for keeping your appointment today!

Contact Information

Last Name _____ First _____ MI _____ Male Female

Street Address _____ Date of Birth _____

City _____ State _____ Zip _____ SS# _____

Best way to contact you: Phone Email Both

Phone: Home _____ Work _____ Cell _____

Email Address _____

(We will not share your email with another party. Email used ONLY for patient communication and newsletters.)

May we leave messages at any of these numbers? Yes No

If no, please explain _____

Employer _____ Full Time Part Time

Retired Student Full Time Student Part Time School _____

In the case of an emergency, who would you like us to contact?

Emergency Contact _____ Phone _____

Provider and Treatment History

Name of Healthcare Provider who referred you: _____

Name of Primary Care Physician: _____

Have you had ANY Physical Therapy for ANY condition in the last 3 years? YES NO

(Failure to provide prior treatment history may result in your treatment not being covered by your insurance).

Referral Information

Would you mind sharing how you heard about us? *(check all that apply)*

- My Physican mentioned you by name
- I was a Previous Patient
- Other: _____
- Referral Sheet from my physician's office
- Friend/Family _____

**If you were referred by one of our former or current patients or clients, please make sure to share their name so we can thank them with a referral gift.*

I would be interested in more information about Sports Performance Adult Fitness Coaching

In order for your therapist to best help you, please answer the following questions as best you can.

Today's Date _____ Date of Onset (exact date is required for work injuries) _____

Area of Injury or Pain: _____

How did this injury occur? _____

As it relates to this injury, please provide the dates of appointments with your healthcare provider:

Date of last appointment _____ Date of next appointment _____

What other treatment have you received for this problem? _____

What diagnostic tests have been done for this condition?

X-ray CT Scan MRI Other _____

What type of work do you do? _____ Are you on light duty? Yes No

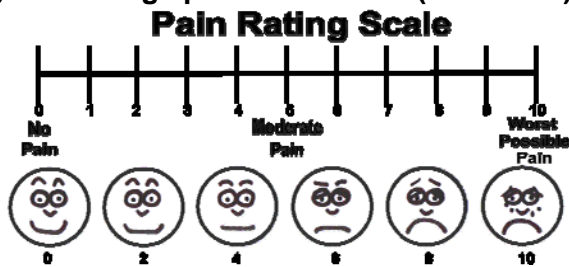
Have you lost time from work? Yes No Off work now due to injury Retired

Please list 3 specific activities you have difficulty performing:

(Examples include dressing, doing dishes, housework, playing sports, gardening, playing with or lifting your children, specific work duties, sitting or standing for more than 10 minutes, unable to walk more than 20 min.)

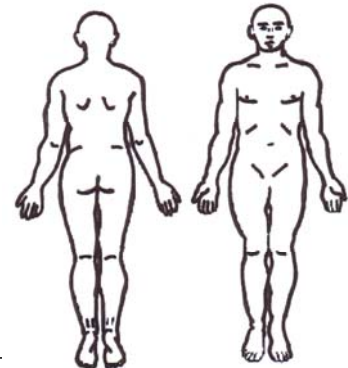
1. _____ 2. _____ 3. _____

Rate your average pain level below (circle one).



Mark on the body your pain locations.

XXX Sharp
OOO Dull
+++ Numb
~ ~ ~ Ache



Please list the following:

ALL medications you are currently taking: _____

Any known allergies: _____

All major surgeries: _____

Do you participate in any competitive sports? YES NO List: _____

Do you currently exercise? YES NO If yes, explain: _____

Indicate below if you have or had any of the following conditions:

Arthritis	Yes <input type="radio"/> No <input type="radio"/>	Epilepsy or Seizures	Yes <input type="radio"/> No <input type="radio"/>	Lung Condition	Yes <input type="radio"/> No <input type="radio"/>
Asthma	Yes <input type="radio"/> No <input type="radio"/>	Fractures	Yes <input type="radio"/> No <input type="radio"/>	Migraines	Yes <input type="radio"/> No <input type="radio"/>
Bleeding Dis.	Yes <input type="radio"/> No <input type="radio"/>	Head Injury	Yes <input type="radio"/> No <input type="radio"/>	Osteoporosis	Yes <input type="radio"/> No <input type="radio"/>
Blood clot	Yes <input type="radio"/> No <input type="radio"/>	Heart Condition	Yes <input type="radio"/> No <input type="radio"/>	Pacemaker	Yes <input type="radio"/> No <input type="radio"/>
Bronchitis	Yes <input type="radio"/> No <input type="radio"/>	Hernia	Yes <input type="radio"/> No <input type="radio"/>	Pinched Nerve	Yes <input type="radio"/> No <input type="radio"/>
Cancer	Yes <input type="radio"/> No <input type="radio"/>	Herniated Disk	Yes <input type="radio"/> No <input type="radio"/>	Rheumatoid Arthritis	Yes <input type="radio"/> No <input type="radio"/>
Depression	Yes <input type="radio"/> No <input type="radio"/>	High Blood Pressure	Yes <input type="radio"/> No <input type="radio"/>	Shortness of breath	Yes <input type="radio"/> No <input type="radio"/>
Diabetes	Yes <input type="radio"/> No <input type="radio"/>	Latex Sensitivity	Yes <input type="radio"/> No <input type="radio"/>	Smoking	Yes <input type="radio"/> No <input type="radio"/>

Are you currently or have you recently been pregnant? Yes No

If you have any disability that might interfere with safe exercise, please explain: _____

If you have other conditions we may need to know about, please explain: _____



CONSENT TO TREATMENT OF MINOR CHILD

I hereby state that I am the legal guardian for the below referenced patient and I authorize the physical therapists and whomever they may designate as assistants at Athletes' Training Center to administer physical therapy treatment care as deemed necessary to my minor child. I understand that at any time I am responsible for communicating any questions I may have in regards to treatment to the treating therapist or supervising therapist at the facility. I further understand it is my responsibility to understand upon conclusion of the evaluation appointment the indications and contraindications for treatment and should notify the evaluating therapists if I do not understand. This consent shall remain in effect through the course of treatment unless revoked in writing.

Today's Date: _____

Name of Minor Patient: _____

Printed Name of Parent or Legal Guardian: _____

Signature of Parent or Legal Guardian: _____

Witness: _____

Patient's Written Acknowledgement of Notice of Privacy Practices

I _____, acknowledge that I have been granted access to notice of privacy practices and was given the ability to request a copy of Athletes' Training Center Notice of Privacy Practices and fully understand the same and have had all my questions answered to my satisfaction.

Patients Signature

Date