Client History Form

New Motion Physical Therapy Inc., PS

Name: _____ **Age** _____ **Today's Date:** _____

Height _____ **Weight** _____

Do you smoke? Yes No **Do you have a pacemaker? Yes No** **Are you pregnant? Yes No**

Do you have any allergies? Please list
Latex? Yes No
_____
_____
_____

Occupation:_____

Sports:_____

What are your wellness/performance goals?
_____
_____
_____
_____
_____
_____

Do you have any chronic injuries or issues that limit your activity?
_____
_____
_____
_____

Describe your current level of physical activity and how long this has been consistent?
_____
_____
_____

How much time per week are you willing to commit to reaching your listed goals?
_____
_____

Are you currently a competitive athlete? Have you been one in the past? If in the past, how long has it been?
_____
_____

Do you have any fear or worry about engaging in physical activity? If so, what are your concerns?
_____
_____
_____

Do you have specific types of exercise you particularly enjoy or dislike?
_____
_____
_____
_____
_____
_____

Please provide a list of all current medications or list them below:
_____
_____
_____
_____
_____
_____

Hospitalizations or surgeries: Please list with dates.
_____
_____
_____
_____
_____
_____

Do you have any other information that would be useful?
_____
_____
_____
_____
_____
_____

Please use the other side of this sheet for medical history questions.

Have you ever been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Blood Clots
- ☐ Stroke
- ☐ Anemia
- ☐ Bone or join infection
- ☐ Chemical dependency
- ☐ Depression
- ☐ Lung problems

- ☐ Tuberculosis
- ☐ Asthma
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Other arthritic conditions
- ☐ Bladder/Urinary tract infection
- ☐ Kidney problem/infection
- ☐ Sexually transmitted disease
- ☐ Pelvic inflammatory disease
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Anxiety

- ☐ Osteoporosis or Osteopenia
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Eye problems/infection
- ☐ Ulcers
- ☐ Liver problems
- ☐ Hepatitis
- ☐ Immunosuppression
- ☐ Fracture or suspicion of fracture

☐ **None of the above**

Other: _____
_____

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)

- ☐ Cancer
- ☐ Heart problems
- ☐ High blood pressure

- ☐ Diabetes
- ☐ Stroke
- ☐ Depression

- ☐ Tuberculosis
- ☐ Thyroid problems
- ☐ Blood clots

In the past month have you been feeling down, depressed or hopeless? YES NO

In the past month have you experienced less interest in/pleasure from things you usually enjoy? YES NO
Is this something with which you would like help? YES YES: BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone tried to hit you or injure you in anyway? YES NO

Reviewed by: _____ **Date:** _____