CORE FIT
FITNESS + SPORTS + REHAB

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For office use only:
Intake signed ☐
Intake Scanned ☐
NP Letter sent ☐
BD Card Printed ☐
Referral TY sent ☐
DC Letter Sent ☐

Patient Name:_____ Date:_____

Date of Birth:_____ Age:_____ Occupation_____

Home Phone:_____ Cell Phone _____ Text message communications? ☐ Yes ☐ No

Address:_____ City _____ Zip _____

E-mail: _____ Email communication? ☐ Yes ☐ No

How did you hear about us? _____

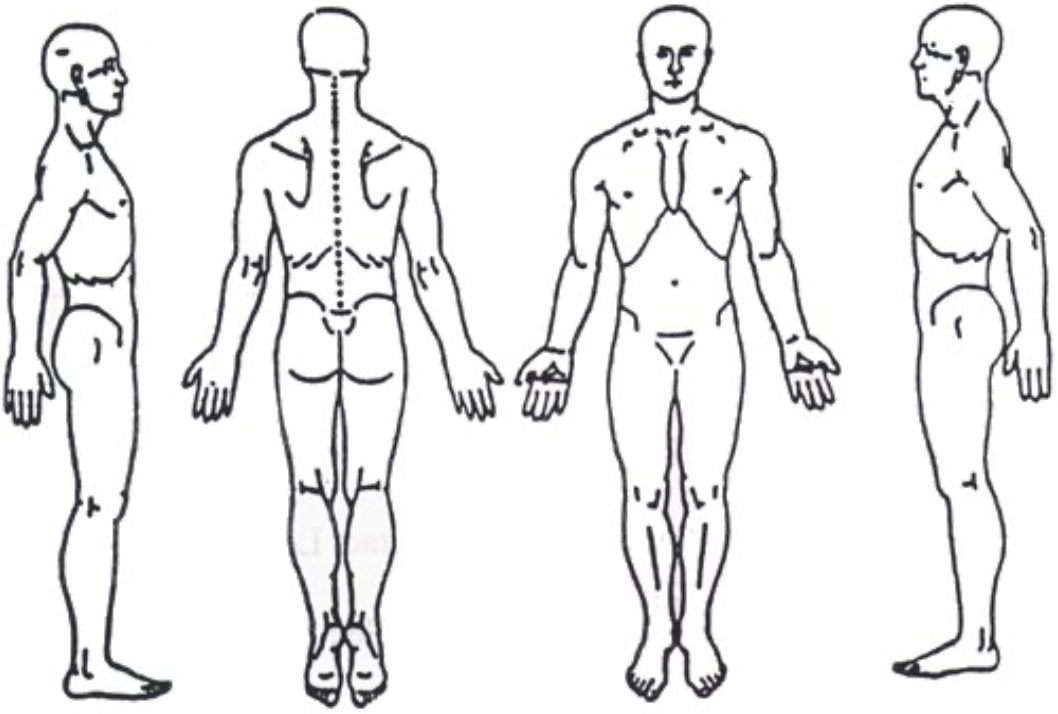
What are we treating you for today? _____

Describe your symptoms:_____

What increases your symptoms?_____

What decreases your symptoms? _____

Date of Injury: _____ Are your symptoms ☐Getting Better ☐ Getting Worse ☐ Staying the same



Mark where you are having pain and the type of pain using the following symbols:

***	Sharp Pain
^^^	Achy or dull
////	Numbness/Tingling
+++	Burning

Rate your pain in the last 48 hours on a scale of 0 to 10 *(0 = No Pain, 10 = worst imaginable pain):*

Pain at rest: 1 2 3 4 5 6 7 8 9 10

Pain with Activity: 1 2 3 4 5 6 7 8 9 10

Does your pain wake you up at night? ☐ Yes ☐No If yes, how many times on average? _____

Have you had any tests for this condition? ☐Xray ☐MRI ☐CT Scan ☐Nerve Conduction ☐Other: _____

Have you seen another physical therapist for this condition? ☐Yes ☐No

If so: What treatments helped? _____

What treatments didn't help? _____

Have you fallen in the last 6 months: ☐ Yes ☐No If yes, how many times? _____

If yes, did the fall(s) result in injury? ☐ Yes ☐No Describe injuries: _____

_____

_____

Level of Physical Activity ☐Low ☐Medium ☐High

Type of activities you enjoy:_____

When are you scheduled to see your doctor again?_____

What do you hope to accomplish with therapy? _____

_____

Medical History

☐ Allergy to latex or adhesives	☐ Diabetes	☐ High Blood Pressure	☐ Currently Pregnant
☐ Arthritis	☐ Epilepsy / Seizures	☐ History of falls	☐ Osteoporosis
☐ Cancer	☐ Headaches	☐ Joint Replacement	☐ Pacemaker
☐ Chest Pain	☐ Hearing Impaired	☐ Kidney Problems	☐ Stroke / CVA
☐ Depression	☐ Heart Disease	☐ Metal Implants	☐ Surgeries
	☐ Hepatitis A, B, or C	☐ MRSA or Staph	☐ Tuberculosis

Medications *(please print or provide a medication list)*

Medication Name	Purpose	Dose and Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies _____