CONNECT

PILATES • PHYSICAL THERAPY • COREALIGN

To ensure you receive a thorough evaluation, please take the time to fill out this important medical history form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Name_____ Date of Birth:_____

Street Address:_____

City:_____ State:_____ Zip: _____

Email address:_____

(for internal use only!)

Phone Number:_____

Occupation: (past or present)_____

Emergency Contact: Name_____ Relationship_____

Phone_____ Alternate Phone_____

Whom may we thank for your referral? _____

Primary Physician: _____ Phone number:_____

Specialist: _____ Phone number:_____

Do you have a referral for PT? YES ◯ NO ◯

Please check any of the following whose care you are under:

☐ Medical Doctor (MD)	☐ Psychiatrist/Psychologist	☐ Personal Trainer
☐ Osteopath	☐ Physical Therapist	☐ Nutritionist
☐ Dentist	☐ Chiropractor	☐ Massage Therapist

If you have seen any of the above in the past three months, please briefly describe for what reason *(illness, medical condition, physical, etc.)*: _____

_____

_____

Does your primary health practitioner know you are participating in physical therapy and/or Pilates? YES ◯ NO ◯

Have you had any prior experience with Pilates? YES ◯ NO ◯

Describe the reason you are seeking physical therapy today: *(if related to trauma or injury please describe how it occurred)*: _____
_____
_____

What would a successful therapy outcome mean for you? *(walking the dog, playing golf, skiing…)*
1. _____
2. _____
3. _____

On a scale of 0-10, what is your energy level? _____
On a scale of 0-10, what is your current pain level? _____ Worst?_____ Best? _____

Do you exercise regularly? YES ◯ NO ◯
If YES, how many days/week? _____ Activities? _____
_____

How much water do you drink each day? _____

In the past 3 months have you had, or do you experience (*check all that apply*):

- ☐ A general change in your health?
- ☐ Difficulty swallowing?
- ☐ Shortness of breath?
- ☐ Any type of infection?
- ☐ Fever/ chills/sweats?
- ☐ Numbness or tingling?
- ☐ Changes in appetite?
- ☐ Change in bowel/bladder function?
- ☐ Dizziness?
- ☐ Nausea/ vomiting?
- ☐ Unexplained weight change?

Which of the following over the counter medications have you taken in the last week? *(check all that apply)*

- ☐ Aspirin
- ☐ Advil/Motrin/Ibuprofen
- ☐ Antacid
- ☐ Tylenol
- ☐ Decongestants
- ☐ Vitamins/minerals
- ☐ Laxatives
- ☐ Antihistamines
- ☐ Other: _____

Please list any PRESCRIPTION medications you are taking:
1. _____ 2. _____
3. _____ 4. _____

Past Medical History: Have you or any immediate family member *(parent, sibling, child)* ever been told you have:

	You	Family Member		You	Family Member
Allergies	☐	☐	High Blood pressure	☐	☐
Anemia	☐	☐	Joint replacement	☐	☐

	You	Family Member		You	Family Member
Arthritis or arthritic condition	☐	☐	Kidney disease	☐	☐
Asthma, hay fever	☐	☐	Osteoporosis	☐	☐
Lung or breathing problems	☐	☐	Peripheral Vascular Disease	☐	☐
Cancer	☐	☐	Pacemaker	☐	☐
Chemical dependency (alcohol/drugs)	☐	☐	Prostate Problems	☐	☐
Circulation Problems	☐	☐	Shortness of breath	☐	☐
Cirrhosis/liver disease/hepatitis	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Skin Problems	☐	☐
Depression	☐	☐	Thyroid problems	☐	☐
Eating disorder	☐	☐	Varicose Veins	☐	☐
Heart problems	☐	☐			

During the past month, have you been feeling down, depressed or hopeless? YES ◯ NO ◯
During the past month, have you had diminished interest or pleasure in doing things?
YES ◯ NO ◯

Please add any other disease or problem you have been treated for by a health care provider in the past 12 months:

_____

Women: Are you (or could you be) pregnant? YES ◯ NO ◯
Number of children: _____ Vaginal ◯ Caesarian ◯ birth?

How many days per week do you drink alcohol? _____
Do you smoke? YES ◯ NO ◯ If YES how many packs/day? _____

I understand the relationship I have with my physical therapist is a partnership. I have the right to ask questions regarding my treatment as well as refuse any part of treatment that has been recommended. My signature gives my consent to be treated.

_____ _____ _____
Patient Name Signature Date

_____ _____
Practitioner Date