JOYCE WILSON

MASTER OF PHYSICAL THERAPY

CLIENT INFORMATION

Date _____

Last Name _____ First Name _____

Street Address _____

City _____ State_____ Zip _____

Date of Birth _____ Age _____ Email Address _____

Home Phone _____ Cell Phone _____

Employer _____ Occupation _____

Emergency Contact _____ Relationship _____ Phone # _____

Description of Problem _____ Date of Onset _____

Have you had surgery for this? ____ Date of Surgery ___ _____ Name of Surgeon

How did you hear about Joyce Wilson, PT? Friend/Patient ___ Who referred you? ____

Doctor _____ Internet _____ Other _____

Cancellation Policy

If you need to change or cancel a session, please at least 24 hours notice. Sessions cancelled with less than 24 hours notice will be billed the rate of one hour, with the exception of emergencies.

Payment is due at time of session unless other arrangements are agreed to beforehand.

JOYCE WILSON

MASTER OF PHYSICAL THERAPY

Client _____ Date _____

CLIENT SELF HISTORY

Do you have, or have you had, any of the following?_____Circle YES or NO

1. Heart or lung trouble	YES	NO
2. Family history of heart disease	YES	NO
3. High blood pressure	YES	NO
4. Allergies	YES	NO
If yes, to what? _____		
5. History of back/neck pain	YES	NO
6. Are you currently pregnant?	YES	NO
Number of children _____		
7. Do you take birth control pills?	YES	NO
8. Recent weight loss	YES	NO
9. Diabetes	YES	NO
10. Cancer	YES	NO
If yes, what type? _____		
11. Colitis or ulcer problems	YES	NO
12. Bowel/bladder problems	YES	NO
13. Arthritis	YES	NO
If yes, where? _____		
14. Osteoporosis	YES	NO
15. History of steroid use	YES	NO
16. History of drop attacks (fainting spells)	YES	NO
17. Epilepsy	YES	NO
18. Do you have Hepatitis: A B or C (circle one)	YES	NO
19. Do you have HIV	YES	NO
20. Do you perceive that you are under any higher than normal stress or pressure at: home?	YES	NO
work?	YES	NO
21. Do you exercise on a regular basis?	YES	NO
If yes, how often? _____ What type? _____		

22. Please list any other medical problems not listed above:

_____

_____

_____

_____

_____

JOYCE WILSON

MASTER OF PHYSICAL THERAPY

Client _____ Date _____

MEDICATIONS

Please list all prescriptions and non-prescriptions you are taking

Drug or Supplement	Dosage	Frequency

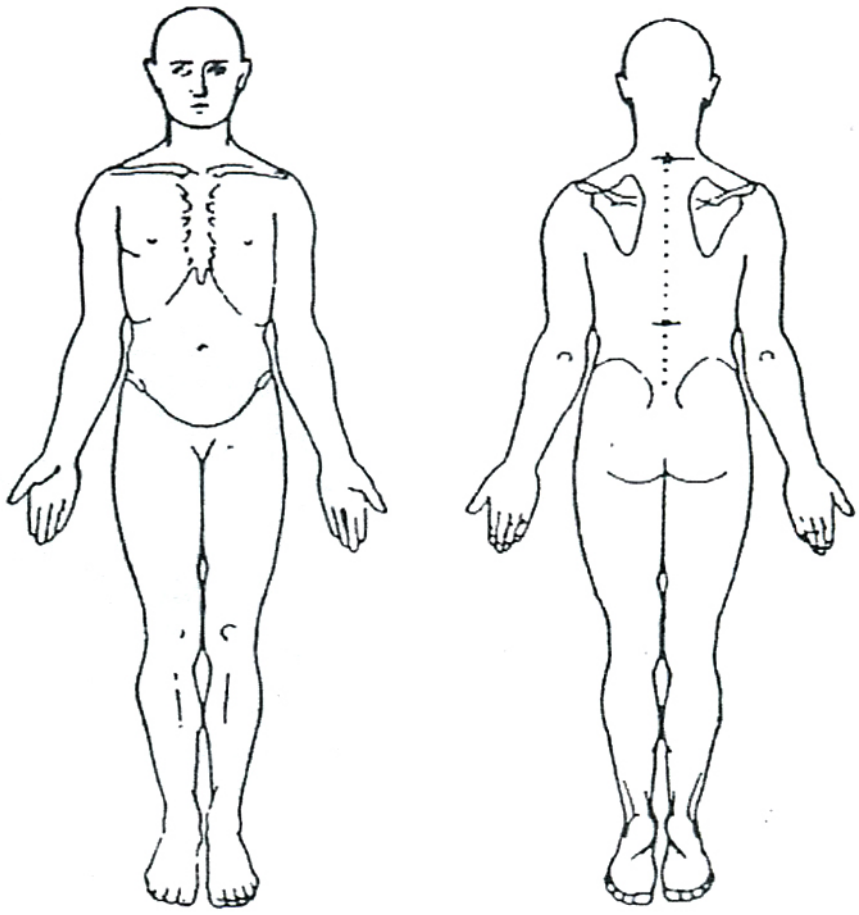
JOYCE WILSON

MASTER OF PHYSICAL THERAPY

Client _____ Date _____

WHERE IS YOUR PAIN?

Please mark on the drawings below the areas where you feel pain



Please rate your pain on a scale of 0 to 10: 0 = best and 10 = worst

At Present _____

At Best _____

At Worst _____