PM CENTER FOR MOVEMENT

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

Name_____ Date of Birth:_____

Address:_____Phone:_____

City:_____ State:_____ Zip:_____

Email address:_____
(for internal use only)

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:_____

Are you under the care of any of the following? (Check all that apply):

☐ 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 the 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 recent injuries/surgeries/procedures/accidents in the past 12 months? If yes, please explain:_____
_____

Is this visit related to an Auto accident, Work Comp, or lawsuit? If yes, please explain.
_____
_____

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. _____

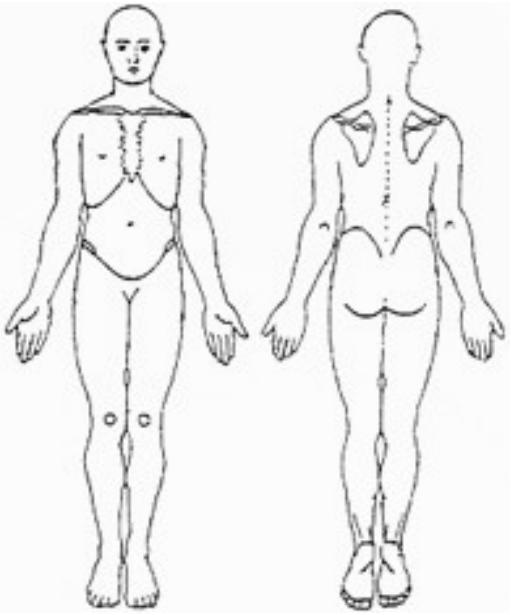
What do you think it would take for you to get better?

_____

_____

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

Please indicate symptoms you are currently experiencing on the diagram below:



Do your symptoms make it difficult for you to sleep well? YES NO
(*circle all that apply*)
Difficulty falling asleep

Waking up due to pain

Difficulty returning to sleep

Describe your daily activities in terms of frequent positions *(circle those that apply)*
Sitting Standing Squatting Bending

Twisting Reaching overhead

Other _____

Do you exercise regularly? ☐ YES ☐ NO

If YES, how many days/week? _____ How long each day?_____

What exercises and/or activities do you enjoy doing?

_____

_____

What activities do you no longer do [or do less] because of pain, injury or other reasons?

_____

How much water do you drink each day? _____

In the past 3 months have you had, or do you experience:

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

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

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

Women: Are you (or could you be) pregnant? _____
Number of children: _____ Vaginal or Caesarian birth? *(circle)*

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 [print] Signature Date

_____ _____
Practitioner Date