

Active Edge Physical Therapy

Thank you for choosing Active Edge Physical Therapy & Sports Medicine! To best serve you, we require the following information. Please print and all information will be confidential.

Patient Information:

Patient Name: _____ Age _____ Male Female
 Primary Phone: _____ Single Married Minor Other
 Employment: _____ Work Phone: _____
 How did you hear about Active Edge PT? _____
 Chief Complaint (body part): _____ Date of Onset: _____ Date last seen by physician: _____
 Description of injury: _____
 Medications (List all prescription and nonprescription): _____

 Previous Surgery / Hospitalization (please note date of surgery/hospitalization): _____

Current Condition-Please circle any problems you have had in the past 12 months?

Chest Pain/Angina	Convulsions or Seizures	Nausea/Vomiting	Depression
Palpitation	Balance/Coordination	Urinary Problems	Memory Loss
Shortness of Breath	Joint Pain/Stiffness	Bowel Problems	Confusion
Wheezing	Swelling of Joints	Eyes/Vision	Nervousness/Anxiety
Chronic/Frequent Cough	Muscle Pain or Cramps	Ears/Hearing	Difficulty Sleeping
Fever/Sweats/Chill	Muscle Weakness	Nose/Mouth/Throat	Sexual Difficulty
Headaches	Numbness or Tingling	Skin Rash	Male-Prostate
Excessive Fatigue	Weight Loss/Gain	Infections	Female-Menstrual
Dizziness	Loss of Appetite	Bleeding/Bruising	Other Condition

List any clinical tests you have had in the past 12 months (Angiogram, CT scan, EKG, X-Ray, Etc): _____

Medical History-Please circle if you ever have had the following?

Spine Injury	Stroke	Kidney Problem	Diabetes
Back Trouble	Heart Problem	Bladder Problem	AIDs or HIV (+)
Arthritis	Circulation Problem	Stomach Problem	Migrane Headaches
Osteoporosis	Respiratory Problem	Eye Disease	Asthma/Allergies
Polio	High Blood Pressure	Skin Disease	Hepatitis
Epilepsy	Low Blood Pressure	Recurring Infection	Other Condition

Active Edge’s Cancellation Policy requires that at least 24 hours advanced notice be provided for all cancelled appointments. By signing below you acknowledge that you understand this cancellation policy and agree to give sufficient notice on all cancelled appointments.

Consent For Care and Treatment: I the undersigned, do hereby agree and give my consent for Active Edge Physical Therapy to furnish medical care and treatment to me (or my child) considered necessary and proper in diagnosing or treating my (or his/her) condition.

 Patient or Guardian (print)

 Patient or Guardian (signature)

 Date