

Date \_\_\_\_\_

First Name: \_\_\_\_\_ Last: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_

May We: Text You? Yes / No Leave a Message? Yes / No Email You: Yes / No

Date of Birth: \_\_\_\_\_ Driver's License: \_\_\_\_\_

Age: \_\_\_\_\_ Sex M / F Occupation: \_\_\_\_\_

Employment Status: Full Time Part-Time Not Working Retired Self-Employed Student

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Referring Doctor Phone \_\_\_\_\_

Primary Doctor: \_\_\_\_\_ Primary Doctor Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

How did you hear of FIT PARSONS? \_\_\_\_\_

What brings you to PT? \_\_\_\_\_

Date of Injury / Onset Date: \_\_\_\_\_ Surgery Date: \_\_\_\_\_

Surgery Type (if applicable): \_\_\_\_\_

**Is this Auto Related?** Yes / No **Work Related?** Yes / No **Accident Related?** Yes / No

**Is there an attorney involved?** Yes / No

**How much pain do you have from 0 (no pain) to 10 (worst pain imaginable)?** \_\_\_\_\_

**Would you say your condition is:** Improving      Staying the same      Getting Worse

**What helps your condition to feel better?** \_\_\_\_\_

**What makes your condition feel worse:** \_\_\_\_\_

**Please List ANY Allergies you have:** \_\_\_\_\_

**Please list all diagnostic exams you have had for your current condition (xrays, MRI, etc)**

\_\_\_\_\_

**Please list any surgeries (and dates) you have had: (separate sheet if needed)**

\_\_\_\_\_

\_\_\_\_\_

**Please list all medications (and doses) you are currently taking: separate sheet if needed**

\_\_\_\_\_

\_\_\_\_\_

**OTHER SERIOUS HEALTH INFO THAT FIT PARSONS SHOULD KNOW ABOUT ME:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Do you or have you had any of the following: Circle all that apply and Explain**

CONDITION	DATE	EXPLAIN
Chest Pain or Shortness of Breath		
High Blood Pressure		
Type I or Type II Diabetes		
High Cholesterol		
Cancer and Type		
Pain that is Worse at Night		
Active Infection, Fevers, Chills, Cold Sweat		
COPD / Heart Attack / Heart Disease / Pacemaker		
Stroke or CVA		
Metal Implants or Pins and where?		
Seizures / Epilepsy / Unexplained falling		
Headaches / Migraines / Blurred Vision		
Dizziness / Ringing in Ears / Difficulty Swallowing		
Blood Clots / DVT / Pulmonary Embolism		
<b>Do you smoke?</b> Packs x Years		
Osteoporosis / Osteopenia		
Unexplained weight gain or loss		
HIV / AIDS or other Auto-Immune Diseases		
Hepatitis / TB		
Are you pregnant?		
Loss of Bowel / Bladder control		
Any Neurological Disorders		
Other Diagnosis / Conditions not Listed Above		

## **FIT PARSONS NOTICE OF PRIVACY PRACTICES AND TERMS OF SERVICE AGREEMENT**

By signing below, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices and Terms of Service Agreement and have therefore been advised of how health information about me may be used and disclosed by FIT PARSONS and how I may obtain access to and control this information.

For a Summary of your Privacy Rights covered under HIPPA, please download:

<https://www.hhs.gov/sites/default/files/privacysummary.pdf>

### **FINANCIAL RESPONSIBILITY**

FIT PARSONS does not accept insurance and payment is due when services are rendered and it is my financial obligation to pay at the time of service. We accept Venmo, PayPal, Cash, and check.

**By signing below, I am acknowledging I understand and consent to the TERMS OF SERVICE as a patient of FIT PARSONS. I understand my rights and agree to and accept full responsibility of my financial obligations to FIT PARSONS. I also acknowledge the information that I have provided is true and accurate to the best of my knowledge.**

\_\_\_\_\_  
Patient's Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Relation to Patient

MEDICATIONS	DOSE	FREQUENCY (TIMES/DAY)

TYPE OF SURGERY	DATE	LEFT / RIGHT SIDE