action sports medicine
specialized training • injury treatment + prevention

New Client Questionnaire

Please Print Clearly

Date:

Name: Last First M

Occupation: Employer: Work ph:

Home Address: Street apt City: zip code:

Home Phone: Cell: Email address:

Social Security # Birth Date: Age: _ / _

Summer Sports? Winter Sports? Primary sport?

Snow/Wake Boarders _ Regular or Goofy?

Goals: 1.
2.

Gym Member? Name

Injury/Surgery History _

Currently taking medications? Yes/No

Name or type of medication _

Do you have or ever had any of the following?

_ Blood Pressure Problems
_ Heart Problems
_ Diabetes
_ Cancer

_ Asthma
_ Lung Disease
_ Circulatory Problems/Clots
_ Leg/Ankle Swelling

_ Fainting/loss of consciousness
_ Easily Bleed or Bruise
_ Allergies (please list):

_ any condition which may affect training/rehab?

Emergency Contact _ Ph#

Payment (self-pay) Options: _ Check _ Cash

Credit Card: _ Master Card/Visa _ AmEx

Credit card # Exp date:

Credit card authorization Signature

How did you hear about action sports medicine?

Please ensure that you complete & sign the appropriate forms:

Training Clients:

_ Page 1 of New Client Questionnaire
_ Liability Form(s)
_ Policy & Procedure Form

Rehabilitation Clients:

_ **Page 1&2 of New Client Questionnaire**
_ Policy & Procedure Form
_ Download or request Privacy Practice Act

Signature (legal guardian if under 18years old) Print Date

New Client Form [page 2] for Physical Therapy

Name: _____ **Referring Physician:** _____

Physician Medical Group (if applicable) _____

Date: _____

Did this occur at work?

Date of Injury/Surgery: _____ Yes/no _____

Insurance Carrier: _____

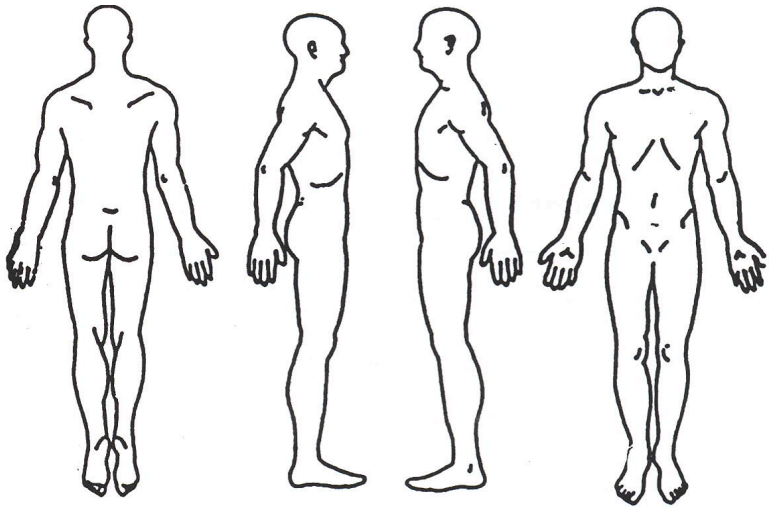
Phone #

for providers: _____ Name of Insured: _____

ID# _____

Group # _____ Relationship to insured: _____

Please mark the area(s) of concern:
P1: primary region
P2: secondary region



Type of Pain:
_aching _sharp _pressure _tingling _numbness _dull _pressure _tightness

Rate your Pain: (0= no pain _ 10 = emergency room admittance) circle the appropriate number below

Current Level: 0 1 2 3 4 5 6 7 8 9 10
At its Best: 0 1 2 3 4 5 6 7 8 9 10 At its worst: 0 1 2 3 4 5 6 7 8 9 10

What makes your symptoms worse? _____

What makes your symptoms better? _____

What activities are you unable to participate in? _____

What do you hope to get out of your therapy besides alleviation of your pain? _____

Questions or Comments you would like to include: _____

_____

Signature (legal guardian if under 18 years old) Print Date

*** please ensure that forms listed on page 1 are also completed & signed along with this 2 page questionnaire**