



Date: _____

Patient's Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Birthdate: _____

Referring Doctor _____

Doctor Address and Phone number _____

Whom may we thank for referring you to our office: _____

Insurance Information

Insured's Name: _____ Birthdate: _____

Insurance Company: _____ Policy No.: _____ Group No. _____

Ins. Phone No.: _____

Insurance Company's Address: _____

Name: _____

Medical History

Please answer yes or no to the following questions:

Alzheimer's	Yes	No
Cardiovascular disease	Yes	No
Huntington's	Yes	No
Cerebral Vascular Accident	Yes	No
Current Infection	Yes	No
Diabetes Type 1	Yes	No
Diabetes Type 2	Yes	No
Fybromyalgia	Yes	No
Fracture or Suspected Fracture	Yes	No
High Blood Pressure	Yes	No
History of cancer	Yes	No
Immunosuppression	Yes	No
Lupus	Yes	No
Muscular Dystrophy	Yes	No
Obesity	Yes	No
Osteoarthritis	Yes	No
Parkinson's	Yes	No
Rheumatoid Arthritis	Yes	No
Traumatic Brain Injury	Yes	No
Difficulty with physical exercise	Yes	No
Advise from physician not to exercise	Yes	No
Recent Surgery	Yes	No
Pregnancy(now or within last 3 months)	Yes	No
Muscle Disorder	Yes	No
Back disorder or pain	Yes	No
Other? _____		

Date of Surgery _____

Please explain any questions answered Yes _____

Are you taking any medications or drugs? _____

When was your last physical exam? _____

Consent to Treatment

Signature _____

Date: _____