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:

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:** _____

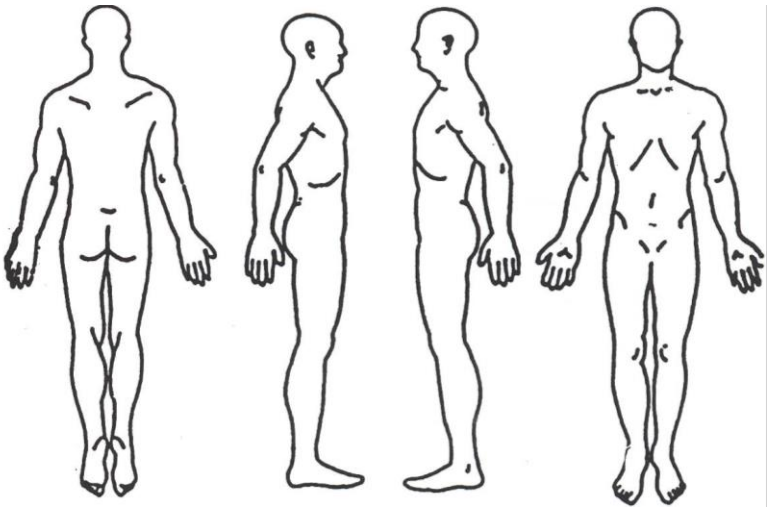
Physician Medical Group (if applicable) _____

Date: _____

Did this occur at work? Yes/no _____

Date of Injury/Surgery: _____

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**