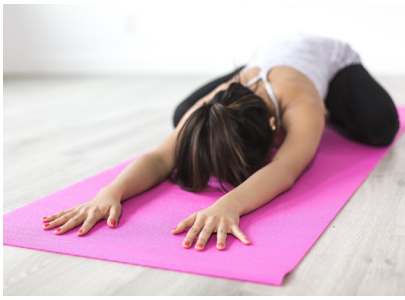


HEALTH INTAKE FORMS

FITNESS FOR HER
Synergy

STEPS TO COMPLETING THESE FORMS

1. Download the Multi-Page PDF
2. Open and complete the fillable documents
   There is NO need to digitally sign these forms. You will have an opportunity to sign them when we see you at your first appointment.
3. Save the completed document
4. Email the saved document to pt@synergyfitnessforher.com

FITNESS FOR HER Synergy

Synergy Fitness for Her- Fitness Prescription LLC

Patient Information

Last Name: _____ First: _____ M.I:_____

Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Cell #: _____ EMAIL: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F Marital Status ☐ M ☐ S ☐ D

Occupation: _____

Would you like to receive a superbill to submit to your insurance? ☐ Yes ☐ No

Emergency Contact

Name: _____ Relationship: _____ Phone #: _____

Primary Care Physician

Name: _____ Phone #: _____ Date of next visit: _____

Injury Type

☐ Work ☐ Auto ☐ Home ☐ Surgery ☐ Other

Who may we thank for your referral? _____

Informed Consent

I understand that Synergy Fitness for Her will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment.

I do hereby agree and give consent for Synergy Fitness for Her to provide care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Synergy Fitness for Her and agree to the liability limitations explained therein.

Signature of Patient or Legal Representative: _____

Relationship to Patient: _____

Printed Name of Patient: _____ **Date:** _____

To help us serve you better and give you a complete and thorough examination, please complete the health background information form below. Thank you!

NAME: _____ **DATE OF BIRTH:** _____

Please check any of the following healthcare providers whose care you are under

☐ Physician (MD, OD) ☐ Dentist ☐ Physical Therapist

☐ Surgeon ☐ Psychiatrist/Psychologist ☐ Other_____

Have ever been diagnosed with any of the following conditions?

☐ **YES** ☐ **NO** Cancer.
If yes, what kind: _____
☐ **YES** ☐ **NO** High blood pressure
☐ **YES** ☐ **NO** Heart Problems.
If yes, what kind: _____
☐ **YES** ☐ **NO** Circulation Problems
☐ **YES** ☐ **NO** Stroke
☐ **YES** ☐ **NO** Diabetes
☐ **YES** ☐ **NO** Thyroid problems
☐ **YES** ☐ **NO** Asthma
☐ **YES** ☐ **NO** Emphysema/Bronchitis
☐ **YES** ☐ **NO** Chemical dependency (eg alcoholism)

☐ **YES** ☐ **NO** Depression
☐ **YES** ☐ **NO** Rheumatoid arthritis
☐ **YES** ☐ **NO** Other arthritis conditions
☐ **YES** ☐ **NO** Blood clots
☐ **YES** ☐ **NO** Osteoporosis/osteopenia
☐ **YES** ☐ **NO** Kidney disease
☐ **YES** ☐ **NO** Allergies.
If yes, list_____
☐ **YES** ☐ **NO** Hepatitis
☐ **YES** ☐ **NO** Tuberculosis
☐ **YES** ☐ **NO** Neurological problems (eg MS, Parkinson's)
☐ **YES** ☐ **NO** Other _____

Please list any surgeries and hospitalizations for other conditions

1. Date:_____ Reason:_____
2. Date:_____ Reason:_____
3. Date:_____ Reason:_____

Have you been treated for any fractures, dislocations, sprains or other significant injuries? If yes, please indicate date and injury below:

1. Date:_____ Injury:_____
2. Date:_____ Injury:_____
3. Date:_____ Injury:_____

During the past month have you been feeling down, depressed or hopeless? ☐ **YES** ☐ **NO**

During the past month have you felt little interest or pleasure in doing things? ☐ **YES** ☐ **NO**

Do you ever feel threatened at home or has anyone hit or tried to injure you in any way? ☐ **YES** ☐ **NO**

For Women: Are you currently pregnant, or think you might be? ☐ **YES** ☐ **NO**

Please mark any of the following that are **NEW** or **UNUSUAL** for you:

☐ **YES** ☐ **NO** Weight loss/gain
☐ **YES** ☐ **NO** Fatigue
☐ **YES** ☐ **NO** Weakness
☐ **YES** ☐ **NO** Joint/muscle swelling
☐ **YES** ☐ **NO** Leg/arm swelling
☐ **YES** ☐ **NO** Numbness/tingling
☐ **YES** ☐ **NO** Dizziness/lightheadedness
☐ **YES** ☐ **NO** Nausea/vomiting
☐ **YES** ☐ **NO** Fever/chills/sweats
☐ **YES** ☐ **NO** Excessive bleeding /bruising
☐ **YES** ☐ **NO** Constipation/diarrhea
☐ **YES** ☐ **NO** Change in urination
☐ **YES** ☐ **NO** Change in vision
☐ **YES** ☐ **NO** Difficulty breathing

Which of the following over–the-counter medications have you taken in the past week?

☐ **YES** ☐ **NO** Aspirin
☐ **YES** ☐ **NO** Anti-inflammatories (Advil, Motrin)
☐ **YES** ☐ **NO** Tylenol
☐ **YES** ☐ **NO** Heartburn/ulcer medication
☐ **YES** ☐ **NO** Vitamin/Mineral Supplements
☐ **YES** ☐ **NO** Other medications/supplements

Please list all prescription medications below:

_____ _____

_____ _____

_____ _____

How many days a week do you exercise? _____

How many cups of coffee or other caffeinated beverages do you drink per day? ___

How many cigarettes do you smoke per day? _____ For how many years? _____ If you quit, when? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer, one glass of wine, or one ounce of hard liquor, how many do you drink per average sitting? ____

Have any of your immediate family members (parents, brothers, sisters) been treated for any of the conditions below?

☐ **YES** ☐ **NO** Diabetes
☐ **YES** ☐ **NO** Cancer
☐ **YES** ☐ **NO** Arthritis
☐ **YES** ☐ **NO** Heart problems
☐ **YES** ☐ **NO** Kidney disease
☐ **YES** ☐ **NO** Stroke
☐ **YES** ☐ **NO** High blood pressure
☐ **YES** ☐ **NO** Depression
☐ **YES** ☐ **NO** Chemical dependence

Patient Signature_____

Therapist Signature_____ **Date**_____

FITNESS FOR HER Synergy

Synergy Fitness for Her- Fitness Prescription LLC

Name: _____ **Date:** _____

What is the primary problem that brings you in today?

_____

_____

Onset? _____

Have you had this problem before? ☐ **YES** ☐ **NO**

If so, how long did it take to resolve? _____

Secondary concern/problem? _____

Type of Pain

☐ Sharp ☐ Burning ☐ Aching ☐ Pins&Needles ☐ Throbbing ☐ Numbness ☐ Other

Rate your average pain on a 0 to 10 scale (0=no pain, 10= worst imaginable pain)

Current_____ Best in 24 hours ____ Worst in 24 hours _____

Symptoms: Come and go ____ Are constant ____ Are constant but change with activity____

When are your symptoms worst? _____

Best? _____

My symptoms are currently

☐ getting better ☐ getting worse ☐ staying about the same

What aggravates your symptoms? _____

What relieves your symptoms? _____

How are you currently able to sleep at night due to your symptoms?

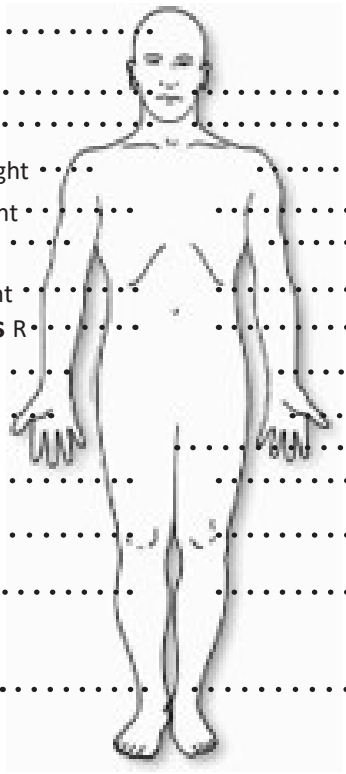
☐ No problem ☐ Difficulty falling asleep ☐ Awakened by pain
☐ Sleep only with medication

Any treatment received so far for these symptoms?

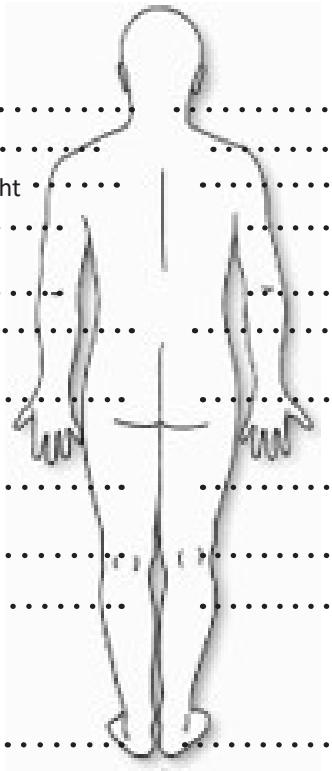
_____

Any special tests? _____

Please mark on the body where your symptoms are located



- ☐ **Head**
- ☐ **Jaw** Right
- ☐ **Neck** Right
- ☐ **Shoulder** Right
- ☐ **Pectoral** Right
- ☐ **Bicep** Right
- ☐ **Ribcage** Right
- ☐ **Abdominals** R
- ☐ **Wrist** Right
- ☐ **Hand** Right
- ☐ **Thigh** Right
- ☐ **Knee** Right
- ☐ **Calf** Right
- ☐ **Ankle** Right
- ☐ **Jaw** Left
- ☐ **Neck** Left
- ☐ **Shoulder** Left
- ☐ **Pectoral** Left
- ☐ **Bicep** Left
- ☐ **Ribcage** Left
- ☐ **Abdominals** L
- ☐ **Wrist** Left
- ☐ **Hand** Left
- ☐ **Groin**
- ☐ **Thigh** Left
- ☐ **Knee** Left
- ☐ **Calf** Left
- ☐ **Ankle** Left



- ☐ **Neck** Left
- ☐ **Shoulder** Left
- ☐ **Upper Back** Right
- ☐ **Tricep** Left
- ☐ **Elbow** Left
- ☐ **Low Back** Left
- ☐ **Glute** Left
- ☐ **Thigh** Left
- ☐ **Knee** Left
- ☐ **Calf** Left
- ☐ **Foot/Heel** Left
- ☐ **Neck** Right
- ☐ **Shoulder** Right
- ☐ **Upper Back** Left
- ☐ **Tricep** Right
- ☐ **Elbow** Right
- ☐ **Low Back** Right
- ☐ **Glute** Right
- ☐ **Thigh** Right
- ☐ **Knee** Right
- ☐ **Calf** Right
- ☐ **Foot/Heel** Right

Identify important activities that you are unable to do or are having difficulty with as a result of your problem/symptoms. Rate your difficulty based on a 0 to 10 scale with 0= "unable to perform" and 10= "no difficulty"

1. _____ 10
2. _____ 10
3. _____ 10

FITNESS FOR HER
Synergy

4810 Hope Valley Rd. Ste 107
DURHAM, NC 27707

SYNERGY FITNESS FOR HER
PHYSICAL THERAPY CANCELLATION POLICY

While some physical therapy offices squeeze as many patients as possible onto their schedule, at Synergy Fitness for Her, when you make an appointment that time is allotted only for you. When you are unable to make it to your appointment and unable to give us 12 hours notice, then many times we have dead time in our schedule that could have been used by other patients eager to get into the practice. We completely understand that unexpected emergencies and illnesses happen; we only ask that you let us know AS SOON AS POSSIBLE. For all cancellations or changes of appointments we ask for 12-hour notification. Any cancellations made less than 12 hours are subject to a $50 cancellation fee at our discretion. Multiple violations of our cancellation policy will increase this fee up to $100, required pre-payment for future booking, or discharge from our practice. We strive to provide the highest quality of personalized care for our patients and simply ask that as a patient you respect our time as we respect yours.

Sincerely,
Your Synergy Fitness for Her Family

I certify that I have read and understand the cancellation policy and that if I cancel with less than 12-hour notice that penalties may apply.

Please Sign: _____

Date: _____