







HEALTH INTAKE FORMS

FITNESS FOR HER

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



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: 🗖 I	M □ F Marital	Status \square M	□s □D
Occupation:					
Would you like to receive a super	bill to submit to yo	our insurance?	I Yes □ No		
Emergency Contact					
Name:		Relationship):		Phone #:
Primary Care Physician Name:		Phone #:		Date of	next visit:
☐ Work ☐ Auto ☐ Home ☐ Who may we thank for your refer					_
Informed Consent I understand that Synergy Fitnes. health information for the purpo any administrative operations re	ses of carrying out	treatment, obta	_	-	
I do hereby agree and give conse in the diagnosing or treating of r			ovide care and trea	ntment that is	considered necessary and prope
I understand that I retain the rigi	ht to revoke this co	nsent by notifyin	g the practice in w	riting at any t	ime.
I acknowledge that I have receive tions explained therein.	ed a copy of the No	otice of Privacy P	ractices of Synergy	Fitness for He	er and agree to the liability limita
Signature of Patient or Legal Re	oresentative:				
Relationship to Patient:					
Printed Name of Patient:			Date:		

Yes NO Cancer Yes NO No Peression Yes NO Peression Yes NO Peression	daar - '					DA	TE OF B	IRTH:		
Surgeon		-	_	-		re you are und	der			
Have very been diagnosed with any of the following conditions? YES NO Cancer. YES NO Rheumatoid arthritis YES NO Rheumatoid YES NO Rheumatoid YES NO Rheumatoid YES NO Rheumatoid YES NO YES NO YES NO YES			•							
YES		-				/chologist		□ Other_		
If yes, what kind:				nowing cor	iaitions?	□ves	Пио	Denression		
YES NO Blood clots YES NO Blood clots YES NO Stroke	If yes,	what kind	:					•	arthritis	
If yes, what kind: UYES									is conditi	ons
YES NO Circulation Problems YES NO Kidney disease YES NO Stroke YES NO Stroke YES NO OS Stroke YES NO Diabetes YES NO									, .	
YES NO No No No No No No No										enia
YES						_			150	
YES										
VES										
YES NO Chemical dependency (eg alcoholism) YES NO Other	_	_								ns (eg MS Parkinson's)
Please list any surgeries and hospitalizations for other conditions 1. Date:				g alcoholisn	n)					
2. Date: Reason: Reaso			-			;				
Bate Reason: Have you been treated for any fractures, dislocations, sprains or other significant injuries? If yes, please indicate date and injury below: Date:										
Have you been treated for any fractures, dislocations, sprains or other significant injuries? If yes, please indicate date and injury below: Date:	2. D	ate:	Reason:							
1. Date:	3. D	ate:	Reason:							
2. Date:	-			-		_	-			date and injury below:
During the past month have you been feeling down, depressed or hopeless? YES NO During the past month have you feel 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 Prowomen: 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 Numbness/tingling YES NO Constipation/diarrhea YES NO Dizziness/lightheadedness YES NO Change in urination YES NO Dizziness/lightheadedness YES NO Change in urination YES NO Dizziness/lightheadedness YES NO Change in vision YES NO Dizziness/lightheadedness YES NO Dizziness/lightheadedness YES NO Change in vision YES NO Dizziness/lightheadedness YES NO Change in vision YES NO Dizziness/lightheadedness YES NO Dizzi	1. D	ate:	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 Numbness/tingling YES NO Constipation/diarrhea YES NO Fatigue YES NO Dizziness/lightheadedness YES NO Change in urination YES NO Weakness YES NO Nausea/vorniting YES NO Change in urination YES NO Joint/muscle swelling YES NO Fever/chills/sweats YES NO Difficulty breathing YES NO Leg/arm swelling YES NO Excessive bleeding/bruising YES NO Anti-inflammatories (Advil, Motrin) YES NO Heartburn/ulcer medication YES NO Anti-inflammatories (Advil, Motrin) YES NO Other medications/supplements Please list all prescription medications below: How many days a week do you exercise? 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? How army of your immediate family members (parents, brothers, sisters) been treated for any of the conditions below? YES NO Diabetes YES NO Heart problems YES NO Depression YES NO Depression YES NO Chemical dependence	2. D	ate:	Injury:							
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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 ☐ Thre	obbing □ Numbness □ Other	
Rate your average pain on a 0 to 10 scale (0=no pain, 10	0= worst imaginable pain)	
Current Best in 24 hours Worst in 24 hours		
Symptoms: Come and go Are constant Are o	constant but change with activity	_
When are your symptoms worst?		
Best?		
My symptoms are currently		
\square getting better \square getting worse \square staying about the s	ame	
What aggravates your symptoms?		
What relieves your symptoms?		
How are you currently able to sleep at night due to you	ır symptoms?	
☐ No problem ☐ Difficulty falling asleep ☐ Awakened☐ Sleep only with medication	d by pain	
Any treatment received so far for these symptoms?		
Any special tests?		

Please mark on the body where your symptoms are located

□ Head · · · · · · · · · · · · · · · · · · ·		
	aw Left Jeck Left	
□ Shoulder Right ···· □S	houlder Left	
	ectoral Left	
□ Bicep Right · · · · · □ B	Sicep Left	
□ Ribcage Right · · · · · · □ R	libcage Left	
□ Abdominals R····□ A	Abdominals L	
□ Wrist Right · · · · □ W	Vrist Left	
	land Left	
100	Groin	
	high Left	
□ Knee Right · · · · □ K	(nee Left	
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□ Ankle Right · · · · · □ A	ankle Left	
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	□ Shoulder Left · · · · · · · · · · · · · · · · · · ·	••□ Shoulder Right
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	/ A A	• -
	□ Elbow Left · · · · · · · ·	··□ Elbow Right
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dentify important activities that you are unable to do or	are having difficulty with as a result of your problem	n/sumntoms Pate
your difficulty based on a 0 to 10 scale with 0= "unable to		nysymptoms. Nate
1.		
2.		
3.		



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: