phone: (509) 350-2506
email: cdotson@OYHPT.com
website: www.OYHPT.com

Client Information Sheet

Date: _____

Name: _____ Date of Birth: _____
(First) (Last) (MI)

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Preferred method of communication: ☐ Call ☐ Text* ☐ Email*

Acceptable methods of communication: ☐ Call ☐ Voice Mail* ☐ Text* ☐ Email*

Employer: _____ Job Title/Description: _____

Job Activities: ☐ Desk Work ☐ Extended Driving ☐ Repetitive Motions ☐ Heavy Lifting

Name of Spouse/Partner (or Parent if Minor): _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Healthcare Team (primary physician, surgeon(s), psychiatrist(s)/counselor(s), chiropractor, physical therapist(s), dietician/nutrition specialist, massage therapist(s), personal trainer, etc.)_____

_____

_____

_____

Signature: _____

I recognize that normal text messaging rates may apply.

*By signing above I acknowledge that the designated forms of communication may not be not secure and accept the risks.

phone: (509) 350-2506
email: cdotson@OYHPT.com
website: www.OYHPT.com

Patient History

Name: _____ Today's Date: _____

What are your hopes/expectations from working with Own Your Health Physiotherapy?

_____

Have you sought help for similar concerns in the past? □ No □ Yes

If so, what worked well? _____

What did not work well? _____

Have you recently had the following tests? □ No □ Yes If **Yes**, check all that apply:

□ X-Ray □ Bone Scan □ CT Scan □ EMG □ MRI □ Blood Test □ Other

If you are not in pain, please skip this section.

Please rate your pain from 0-10 with 0 being no pain and 10 being the worst pain you can imagine: _____

In the past week, have you had even one brief moment without pain? □ No □ Yes

Does your pain move or radiate anywhere? □ No □ Yes

If so, where? _____

Have you had any changes in your bowel, bladder, or sexual function as a result of your symptoms?

□ No □ Yes If so, please describe: _____

Do you have numbness, tingling, or weakness not related to pain? □ No □ Yes

If so, where? _____

Please list any medical conditions/diagnoses you have had: _____

_____

Please list any major surgeries you have had: _____

_____

Please list your current medications or provide us with a copy of your medication list. _____

_____

Is there anything else you feel may help us best meet your needs? _____

_____