Elizabeth Rogers Pilates & Physical Therapy, PLLC
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Client Information

Name:		Birth date:	Gender: M or F
Address:			
City:	State:	Zip:	
Home #: ( )	Cell #: ( )	Work #: ( )	
Email address:			
Is there someone we can thank for your referral?			

Emergency Contact:

Name:	Phone #: ( )
Relation:	

Health History

Have you **ever** had the following? Circle N or Y or leave blank if uncertain.

Chickenpox	N	Y	Heart Disease	N	Y	Vision issues	N	Y
Whooping Cough	N	Y	High Blood Pressure	N	Y	Multiple Sclerosis	N	Y
Tuberculosis	N	Y	Low Blood Pressure	N	Y	Dizziness/Vertigo	N	Y
Aids or HIV	N	Y	Mitral Valve Prolapse	N	Y	Chronic cough	N	Y
Thyroid Disease	N	Y	Migraine Headaches	N	Y	Asthma	N	Y
Epilepsy	N	Y	Infectious Mono	N	Y	Hernia	N	Y
Kidney Disease	N	Y	Stroke	N	Y	TMJ issues	N	Y
Hepatitis	N	Y	Diabetes Type 1	N	Y	Chronic back problem	N	Y
Ulcer	N	Y	Diabetes Type 2	N	Y	Arthritis	N	Y
Bleeding Tendency	N	Y	Cancer	N	Y	Depression	N	Y
Anemia	N	Y	If yes, type: ______________________			Anxiety	N	Y
How many hours do you sleep per night? _____<7 _____7-9 _____>9						Pregnancy	N	Y
How many car accidents have you been involved in? ______						# of vaginal births _____	Year(s):	
How much alcohol do you drink? ______ drinks/day ______ drinks/week						# of c-sections _____	Year(s):	
How many days/week do you exercise? ______						Do you smoke?	N	Y

Exercise/activities/sports you enjoy:

Previous hospitalizations/surgeries/serious illnesses:

Medications (including over-the counter medications)**:**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status.

Signature of patient, parent or guardian:	**Date:**