THE PARKINSON'S FITNESS PROJECT

NEUROFITNESS TRAINING / PHYSICAL THERAPY

Return completed forms to:
106 Lakeside Ave
Seattle, WA 98122
admin@theparkinsonsfitnessproject.com

**PATIENT REGISTRATION**

Name: _____.

Address: _____.

City:_____State: _____ ZIP: _____.

Home Phone:_____Cell Phone: _____.

Email: _____.

Birthdate: ____/____/_____ Sex: _____.

Emergency Contact Name: _____Phone: _____.

Relationship:_____.

Occupation: _____.

Referring Physician:_____ Phone: _____.

Address: _____.

Insurance Information: WE MUST HAVE A COPY OF YOUR INSURANCE CARD ON FILE

Primary Insurance Company: _____.

Customer Service Number: _____.

Name of Policy Holder: _____Date of Birth: ____/____/_____

Relationship: _____ID#: _____.

Group#: _____.

Secondary Insurance Company: _____.

Customer Service Number: _____.

Name of Policy Holder:_____Date of Birth:____/____/_____

Relationship: _____ID#: _____.

Group#:_____.

Please sign to verify the above information is accurate

Patient Name or Responsible Party:_____.

Signature: _____Date: _____.

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Questions: 304-506-3876

**MEDICAL HISTORY**

Name: _____Birthdate: ____/___/____.

What problems bring you here today:_____.

_____.

When were you diagnosed/When did symptoms start:_____.

What makes symptoms better:_____.

What makes symptoms worse:_____.

Do you have pain?_____ If so, please rank (0 NO PAIN, 10 EXTREME PAIN): Worst____Best____.

How many falls have you had in the past year?_____.

Please list all relevant medications (You can also bring a list with you to your first visit)

_____.

Please list all past medical history: _____.

_____.

Please list all past surgeries: _____.

_____.

Please list all allergies: _____.

During the past month, have you felt down, depressed, or hopeless:_____.

What is your goal for therapy:_____.

Is there anything else you would like us to know:_____.

Patient Name:_____.

Signature: _____Date: _____.