360 PHYSICAL THERAPY & WELLNESS
PREVENT. PRESERVE. PROGRESS.

360 Physical Therapy & Wellness
11840 West Market Place Suite G
Fulton, MD 20759
Phone: 301.957.2564
Fax: 301.957.2565

PRE-EXAMINATION FORM

Name_____Date_____

Age_____ Height_____Weight_____Sex (Male / Female)

Occupation_____Working (YES / NO)

Are you currently experiencing pain? (YES / NO) Location(s)_____

How long have you had pain? _____ Have you experienced this before? (YES / NO)

On a scale of "0" to "10" where 0 = no pain and 10 = worst pain imaginable, please circle **ONE** NUMBER

0 1 2 3 4 6 7 8 9 10

Please list your current active medications and dosage:

_____

_____

Medical History (**Please Circle All That Apply)**:

Abnormal Bleeding	Anemia	Artificial Heart Valve	Cancer
Diabetes	Emphysema	Fainting	Glaucoma
Heart Murmur	High Blood Pressure		Hepatitis (A B C)
Liver Disease	Pacemaker	Shingles	Stroke / TIA
Ulcers	Asthma	Difficulty Breathing	Arthritis
Heart Defect	Heart Failure	Epilepsy	Headaches
Heart Attack	HIV/AIDS	Coronary Artery Disease	Joint Replacement
Renal Disease	Rheumatoid Arthritis		Sinus Problems
Sexually Transmitted Diseases		Thyroid Disease	Sickle Cell Anemia

Other:_____

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Please list any surgeries and their respective dates:

_____

Terms of Service:

I, the undersigned, certify that I have insurance coverage, and assign directly to 360 Physical Therapy & Wellness all insurance benefits, if any otherwise payable to me for services rendered. I consent to the diagnostic procedures and treatment by the physical therapist necessary to treat my condition(s). I acknowledge that the information provided is accurate and to the best of my knowledge and that this information will be held under the strictest confidence under HIPAA regulations.

Name (Patient)_____

Name (Parent / Guardian, if applicable) _____

Signature_____ Date_____