Eastern Sierra Physical Therapy and Wellness

Patient Name: _______________________________DOB:_____________Phone#:___________________

Email Address (for notification of events, educational material, updates, etc.): _____________________

How did you hear about us?: __________________

Where are your symptoms located?______________________ When did they start?________________

List any significant operative and invasive procedures in your lifetime:_____________________________

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List of Current Medications (including herbal preparations) and dosages:

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Do you have any metal in your body? Y/N If yes, where: ____

Allergies: ____

Pacemaker? Y/N Hearing Aides? Y/N Pregnant? Y/N

List any current or prior medical conditions you have. Diabetes High Blood Pressure
Infectious Blood Disease Upper Respiratory Disease Osteoporosis Heart Issues (MI, CHF)

Stroke Digestive Problems Mental Health Problems
Other: ____

A 24-hour notice is required prior to canceling or changing a physical therapy appointment. A $50 charge will be assessed without this 24-hour notice. This $50 charge is not covered by your insurance. If you have an emergency please let me know by calling and you will not be charged. Please initial stating that you understand the cancellation policy and agree to it.
Patient initials _______
I hereby authorize the staff of Eastern Sierra Physical Therapy and Wellness to evaluate and perform the treatment plan based on the evaluation.

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Signature of Patient/Parent/Legal Guardian Date