BALANCED

PHYSICAL THERAPY | PILATES & PERFORMANCE CENTER

Last Name _____ First_____ MI ____

DOB _____ Sex _____ Marital Status _____

Home Address _____
City _____, State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Emergency Contact & Relationship _____
Phone _____

Have you had physical therapy or Pilates this year? _____ If so, where
_____

How did you hear about us? _____

Primary Physician Name _____ Phone _____

Registering for Session: _____
Day /Time _____
Registering for Session: _____
Day /Time _____

_____ _____
Client / Legal Guardian Signature **Date**

20325 N. 51st Ave, Bldg 6, Ste. 148, Glendale, AZ 85308
Phone 623.249.3216 Fax 623.249.3218

RELEASE & WAIVER AGREEMENT

I, _____ voluntarily desire to participate in exercise conducted by any instructor at Balanced Physical Therapy located at 20325 N. 51st Ave, Bldg 6 Ste 148, Glendale, AZ 85308.

I understand and agree to the following:

1. I understand that it is my responsibility to consult with a physician before beginning any exercise program.
2. I am aware that there exists the possibility of certain conditions occurring during or following training and/or exercise. These include, but are not limited to: mild light headaches, fainting, abnormalities of blood pressure and/or heart rate, injuries to bones, joints and muscles, neck or spinal injuries, ineffective heart function, and in rare but serious instances, heart attack, stroke, or death.
3. I understand that I am voluntarily participating in these activities and understand that I may, at any time, choose not to participate in a particular activity.
4. I agree and have been informed that exercise involves possible risks and all exercises are undertaken at my sole risk and that neither Balanced Physical Therapy, nor its directors, employees or agents shall be liable to me nor any other person, for any claims, demands, actions or causes of action for injuries or other damages, whatsoever, to my person or property arising out of or connected with my use of Clinic services, facilities, equipment or my participation in Clinic activities, classes or programs. I do hereby release and discharge Balanced Physical Therapy thereof from all such claims, demands, actions or causes of actions for such injuries or damages sustained by me.

I HAVE READ THE ABOVE STATEMENTS AND UNDERSTAND THE CONDITIONS.

_____ _____
Client Signature **Date**

_____ _____
Guardian/Parent Signature (if under 18 y/o) **Date**

_____ _____
Witness **Date**

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WELLNESS MEDICAL HISTORY QUESTIONNAIRE

Please fill out this form as complete as possible. It will assist in your goals with your sessions.

Name: _____ Age: _____ Height: _____ Weight: _____
Occupation: _____ Hobbies: _____
Sport Activities: _____

MEDICAL HISTORY

Please check all the conditions that apply to you either in the present or the past:

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chest Pain / Angina
- ☐ Heart Attack
- ☐ Stroke
- ☐ TIAs
- ☐ Heart Disease
- ☐ Heart Surgery
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Hypoglycemia
- ☐ Bronchitis
- ☐ COPD / Emphysema
- ☐ Asthma – seasonal
- ☐ Asthma - exercise induced
- ☐ Headaches
- ☐ Epilepsy
- ☐ Loss of Bowel
- ☐ Loss of Bladder
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Urinary Tract Infection
- ☐ Gall Bladder / Appendix
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Loss of Vision / Visual Disturbances
- ☐ Difficulty Swallowing
- ☐ Dizziness
- ☐ Hearing Loss
- ☐ Cancer Type: _____ Result: _____
- ☐ Ulcers
- ☐ Thyroid Problems: ☐ HYPER ☐ HYPO
- ☐ Depression
- ☐ Chemical Dependency (Alcohol / Drugs)
- ☐ Smoker
- ☐ Psychological / Emotional Problems
- ☐ PTSD
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Gout
- ☐ Ehlers–Danlos syndrome
- ☐ Scoliosis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pregnant
- ☐ OTHER: _____ _____
- ☐ Do you smoke? How many cigarettes per day? _____
- ☐ How many times during the week do you drink alcohol? _____
- ☐ Any other substances do you regularly use? _____

If you marked any of the above, please give a brief explanation:_____
_____
Any past injuries? No Yes, _____
Current Medications (list medication and for what condition)
_____
Known Allergies: No Yes, _____

GENERAL HEALTH

Do you exercise regularly? _____ If so, what/when _____
_____
Do you have difficulty sleeping? No Yes, why do you think _____
Are you in any pain? No Yes, _____
Are you on a special diet prescribed by your physician? No Yes, what _____
Have you had any unexplained weight loss in the past 3 months? No Yes _____
Have you noticed any lumps or thickening of muscle or skin on your body? No Yes _____
Any current activity and/or work restrictions from your physician? No Yes, _____

List your goals for this consultation and/or sessions:

1. _____
2. _____
3. _____

_____ Date _____
Client Signature

_____ Date _____
Instructor Signature

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CREDIT CARD INFORMATION

At Balanced Physical Therapy we give the highest 1 on 1 quality patient care. Each patient is scheduled for 1 hour with one of our Physical Therapists. It is important that you follow our Cancellation Policy as our therapists have booked that time for you.

Having the 24 hour notice gives us the opportunity to fill the vacant spot with another patient who is on the waiting list. Because of this, it is our policy to have a credit card on file for each patient. Your card will only be billed if you no show for your scheduled appointment, or you do not cancel within 24 hours. We do understand that emergencies come up, and adjustments will be made accordingly. Below please find our cancellation policy.

Cancellation Policy: At Balanced Physical Therapy we have a 24 hour cancellation policy. Failure to give 24 hours notice or failure to arrive for a therapy session without notifying the office will result in a $75.00 fee.

Name: _____

Credit Card Type: _____ Card Number: _____

Expiration Date: _____ Billing Zip Code: _____

Signature: _____ Date: _____

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All PT sessions are 1-on-1 with a PT the entire session!

Please read thoroughly and initial. Your signature is required at the bottom. Thank you!

Top reasons NOT to cancel or "no-show" your scheduled appointments:

1) Consistent and timely implementation of treatments is the KEY TO RECOVERY.
   INITIALS _____

2) Prevents regression or the loss of gains acquired from previous sessions.
   INITIALS _____

3) Allows your clinician to assess your current symptoms (better or worse) more consistently for BEST outcome and results.
   INITAILS _____

4) Avoid unnecessary cancellation fee of $75. This fee is charged when appointments are cancelled less than 24 hrs of appointment time.
5) INITIALS _____

6) Unlike other physical therapy clinics, at Balanced your Physical Therapist's hour is dedicated to YOUR HOUR. If you are unable to re-schedule in a timely and effective manner, then your therapist will not be able to see another patient and will have NO ONE to see for that hour. It is a "wasted" hour for a very beneficial session for someone!
   INITIALS _____

7) Keep in mind, if you cancel frequently, we might have to make arrangements that work for both your schedule and the physical therapists schedule to both work effectively.
   INITIALS _____

   Patient Signature: _____ Date: _____

*Thank you for your **understanding and your commitment** to your physical therapy experience here at Balanced. We are happy to be meeting you and welcoming you into our family. You are very important to us!*

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