Member Information

Today's Date: _____/_____/_____

FIRST NAME: _____ **PREFERRED NAME:** _____ **LAST NAME:** _____

How Did You Hear About Us?

___ Physical Therapy @ the Cantrell Center
___ Cantrell Employee: _____
___ My Doctor - Dr. _____
___ Friend/Relative: _____
___ Employer: _____
___ Website
___ Facebook
___ Cantrell Center 5K
___ Other: _____
_____

Friends of the Cantrell Wellness Center are very special to us. Was there a specific person that recommended the Cantrell Wellness Center?
We would like to thank them.

Name: _____

_____
ADDRESS

_____

_____
CITY STATE ZIP CODE

Member Details

Gender: _____ Age:_____ Date of Birth: _____/_____/_____

Address: _____ _____ _____ _____
Street & Number City State Zip Code

Home Phone: (____) _____ Cell Phone: (_____) _____

Enable Appointment Reminders via text*? ☐ Yes, Cell Provider: _____ ☐ No
*Message & Data Rates May Apply

Emergency Contact Information:

Name: _____ **Phone:** (_____) _____ **Relation:** _____

Email Address (PLEASE PRINT):_____

Marital Status
M S D W
☐ ☐ ☐ ☐

Employment Status
☐ **Employed*** ☐ **Unemployed** ☐ **Student** ☐ **Retired**

*Your Occupation: _____

Your Employer: _____ Work Phone: (_____) _____

Spouse/Guardian Information

Spouse /Guardian Name: _____ Phone: (____) _____
First MI Last

Personal Medical History

PLEASE CHECK ALL THAT APPLY:
☐**SMOKE** ☐**DRINK** ☐**DRUGS** ☐**EXPOSED TO HIV** ☐**PREGNANT – IF SO, HOW LONG?** _____

	AIDS		GOUT		MIGRAINES
	ALZHEIMER'S		HEART CONDITION		MULTIPLE SCLEROSIS
	ALLERGIES		HEPATITIS		OSTEOPOROSIS
	ASTHMA		HIGH BLOOD PRESSURE		PACEMAKER
	CANCER		HIGH CHOLESTEROL		PARKINSON'S DISEASE
	CEREBRAL PALSY		IMMUNE DEFICIENCY		PERIPHERAL NEUROPATHY
	DIABETES		IMPAIRED VISION		RHEUMATOID ARTHRITIS
	EPILEPSY		INCONTINENCE		SHORTNESS OF BREATH
	EXCESSIVE BLEEDER		INFECTIOUS HEPATITIS		STROKE
	FIBROMYALGIA		JOINT REPLACEMENT		SWELLING
	FRACTURES		LUPUS		OTHER:

Are you under the care of a cardiologist? If so, who? _____

Please list your medications and indicate the reason prescribed:

Medication: _____ prescribed for: _____
Medication: _____ prescribed for: _____
Medication: _____ prescribed for: _____
Medication: _____ prescribed for: _____
Medication: _____ prescribed for: _____
Medication: _____ prescribed for: _____
Medication: _____ prescribed for: _____
Medication: _____ prescribed for: _____

Are you currently experiencing any pain? If so, then describe symptoms and location:

_____

_____

Physician seen for wellness physical: _____ Date of visit: _____

If you were seen for your wellness physical by someone other than your family physician, please state your Primary Care Physician: _____

May we send progress reports to him/her? ☐ Yes ☐ No

Wellness Goals

1. What personal fitness goal would you like to achieve here at the Cantrell Wellness Center?

_____

_____

2. What area of your body would you like to improve on the most? _____

3. How many times a week do you see yourself using the facility? _____