NEW CLIENT INFORMATION

LOCATION: 7844 Green Meadows Drive   Lewis Center, OH 43035

PHONE: 740-549-7041

Welcome to our Wellness Center!

To learn more visit our website: www.PTadvantage.com

You can also find us on Facebook and Instagram @AAPTOHIO

Please complete the applicable forms on the following pages and bring them with you at the time of your appointment.

Bring your insurance card(s) and ID. Also bring your physical therapy referral or prescription from your medical doctor, if applicable. For workers compensation claims, bring your BWC and MCO cards and a C-9 authorization from your medical doctor on record. For auto accidents, details are required to be provided to our staff prior to scheduling your first appointment.

Wear comfortable loose fitting sportswear to your appointments.

Thank you and we look forward to meeting you!

Mark Read, PT,   Meghan Howes, PT, PhD
Fauzia Asad, PT, CLT-LANA
Shannon Quick, CMM, HITCM-PP, Cert. NatMed, Cert. Sound Therapist

PATIENT INFORMATION COLLECTION FORM

Patient Name ________________________________ Birth date ______________ Age ______ Male____ Female ___

Address ____City ______________ State _____ Zip _______________

Home Phone ( ) ____________ **Cell Phone** ( ) ______________ Marital Status: Single ___ Married ___ Other ___

SSN __________________________ Email address: ____

Spouse or parent's name (as applicable) __________________________________ Phone Number ( ) ___________

Employer / School Name _______________________________________ Address _____________________________

Emergency Contact ___________________ Phone ( ) ________________ Referred by ______________________

Your Physician's name(s) ____________________________________ Phone ( ) _____________________________

Address ____

I understand that AAPT will use the above address and/or phone numbers to contact me and leave messages if necessary regarding: scheduling appointments, appointment reminders and other information.
□ Yes you may contact me □ No, please use alternate method
Alternate method of contact ____
Initials of Patient/Legal Representative _______________________________

GUARANTOR INFORMATION (Person responsible for paying for this appointment) Write "same as patient" if patient is Guarantor.

Name_________________________ Relationship to patient ____________________ Home Phone ( ) _________

Address___________________________ City ___________ State______ Zip _____ Other Phone ( ) _________

Social Security Number ______________________________ Date of Birth ____________________________

Guarantor's Place of Employment ______________________ Employer Phone __________________ Insurance? Y/N

Guarantor's Employer Address ______________________________ City _______________ State ___ Zip _________

Insured's (Subscriber) Information (Person carrying insurance on this patient)

Name _____________________________Relationship to patient ________________Home Phone ( ) _________

Address _____________________ City _____________ State __ Zip ______

Subscriber's Place of Employment __________________________ Phone # ( ) _____________________

Subscriber's Employer Address ___________________________ City ____________ State ______ Zip _________

Social Security Number ______________________________ Date of Birth _________________

INSURANCE__________________ Insurance ID Number __________________ Insurance Group Number __________

LATE CANCELLATION AND MISSED APPOINTMENT POLICY

I understand that the following fees may be charged for the stated reasons:

- There is a $45 fee charged to clients who fail to cancel their appointments without giving Athletic Advantage a business day 24-hour notice, and if we are unable to schedule another patient in that appointment time.
- There is a $65 fee charged to clients who simply fail to arrive for their scheduled appointments without any notice whatsoever.

Signature_________________________________ Printed Name:___________________________ Date____________

HEALTH QUESTIONAIRRE

Patient Name: ____ Date: ____________________

Do you have history of any of following:

_______ Heart Condition__________________
_______ High Blood Pressure
_______ Pacemaker
_______ Diabetes
_______ Cancer: Area Affected_____________
_______ Pregnancy
_______ Are you Pregnant?

_______ Neurological disorders____________
_______ Skin Conditions
_______ Blood Born illness (HIV, Hep A/B/C, TB)
_______ Anxiety/ Depression/Panic Disorders
_______ Pain at night
_______ Osteoporosis/ Osteopenia
_______ Other_________________________

SURGICAL AND INJURY HISTORY

Please list all surgeries and injuries below and when they occurred (approximate)

________________________Date:__________ ______________________ Date:__________

________________________Date:__________ ______________________ Date:__________

________________________Date:__________ ______________________ Date:__________

MEDICATIONS

Please list any current Medications/Supplements that you are currently taking

___________________ ___________________ ___________________ ___________________

___________________ ___________________ ___________________ ___________________

___________________ ___________________ ___________________ ___________________

What is your reason for coming to therapy today? ____

When did your problem begin? ____

How did your problem start? ____

Are you allergic to adhesives/tape, latex, or bee stings? **Yes** **No** **If Yes, please list** __________________

Have you had physical therapy previously for the same problem? **Yes** **No**

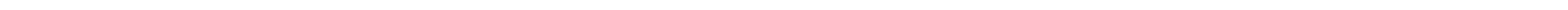
Are you receiving other treatments for this problem at this time? **Yes** **No** ***If yes, please list**:* _____________

____

What kind of tests have been done for your **current** problem? (*check if applicable*) **MRI** **X-Ray** **CT Scan** **Myelogram**

Or List: ___________________________________ **Results:** ______________________________________

Have you been hospitalized in the past year **for this condition**? **Yes** **No** *If yes, when and for how long?:* ______



Patient Name: ______________________________________ **Date:** ___________________

PAIN

Do you have pain now? No Yes, Location/Type: ____

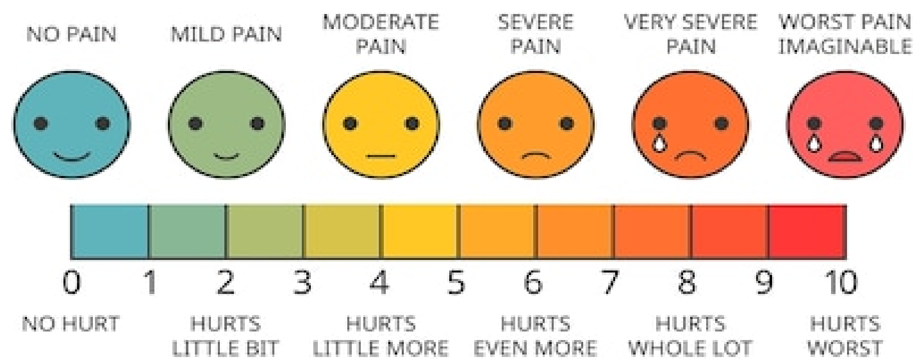
What makes it better? ____

What makes it worse? ____

Does the pain interfere with your daily life? **No** **Yes**, Describe: _________________________________

RATE YOUR PAIN ON A SCALE OF 0-10 (0 BEING NO PAIN AND 10 BEING THE WORST) _____/10 Today

(see scale below)



Type of Pain: **Constant** **Intermittent** **Shooting** **Dull** **Sharp Ache**

Pain relieved by: **Heat** **Ice** **Rest** **Medication** **Movement**

BALANCE:

1. Have you fallen in the last 6 months? **Yes** **No** How many times? _____________

2. Have you had a decrease in your activity level because of a fear of falling? **Yes** **No**

3. Are you reluctant to leave your home because of a fear of falling? **Yes** **No**

What are your goals as a result of attending physical therapy?

Please check appropriate box.

- ☐ Decrease pain
- ☐ Less difficulty with work activities
- ☐ Sleep longer _______ hours
- ☐ Improve movement
- ☐ Return to recreational activities / sports
- ☐ Improve strength
- ☐ Stand longer ___ minutes / hours.
- ☐ Sit longer ___ minutes / hours.
- ☐ Less difficulty with home activities

Anything else: ____

____

ATHLETIC ADVANTAGE WELLNESS CENTER

WELLNESS CONCERN CHECKLIST

Please check all concerns that apply to you.

At Athletic Advantage, we believe in treating the whole person.
Your responses help us better understand your needs and support your wellness journey.

Name: ______________________ Date of Birth: ______________________

Phone Number: ______________________ Email: ______________________

BODY CONTOURING & PERFORMANCE

BODY CONTOURING & SHAPE

- ☐ Desire to reduce stubborn fat
- ☐ Areas resistant to diet/exercise
- ☐ Wanting more defined body contours
- ☐ Postpartum body changes
- ☐ General body reshaping goals

MUSCLE TONE & DEFINITION

- ☐ Low muscle tone
- ☐ Loss of core strength
- ☐ Weak abdominal muscles
- ☐ Desire to improve glute lift/tone
- ☐ Want more muscle definition
- ☐ Desire to strengthen arms, thighs, calves, abs, and glutes

SKIN TIGHTNESS & FIRMNESS

- ☐ Mild to moderate skin laxity
- ☐ Weak abdominal wall support
- ☐ Loose skin after weight loss
- ☐ Poor tissue firmness

METABOLISM & BODY COMPOSITION

- ☐ Slow or stalled fat-loss progress
- ☐ Trouble building muscle despite training
- ☐ Wanting more efficient workouts
- ☐ Currently taking a GLP-1

FUNCTIONAL & LIFESTYLE CONCERNS

- ☐ Back pain related to weak core
- ☐ Poor posture
- ☐ Reduced athletic performance
- ☐ Low physical stamina
- ☐ Longevity and maintaining mobility
- ☐ Weakness
- ☐ Instability
- ☐ Back pain
- ☐ Neck pain
- ☐ Stiffness
- ☐ Walk with assistance
- ☐ Past surgery on bone, muscle, or joint
- ☐ Arthritis
- ☐ Currently in physical therapy
- ☐ Neuropathy
- ☐ Tendonitis
- ☐ Carpal tunnel
- ☐ Plantar fasciitis
- ☐ Hip pain
- ☐ Knee pain
- ☐ Shoulder pain

IF YOU CHECK YES TO ANY OF THESE,
A TEAM MEMBER FROM THE WELLNESS CENTER MAY BE IN CONTACT WITH YOU.

PELVIC FLOOR & BLADDER HEALTH

URINARY INCONTINENCE

- ☐ Stress incontinence
- ☐ Urge incontinence (sudden, strong urge to urinate)
- ☐ Mixed incontinence (both stress + urge)
- ☐ Frequent accidental leakage
- ☐ Frequent nighttime urination (nocturia)
- ☐ Difficulty holding urine
- ☐ Increased urinary frequency

PELVIC FLOOR WEAKNESS

- ☐ Weak pelvic floor muscles
- ☐ Feeling of pelvic heaviness or pressure
- ☐ Core instability
- ☐ Reduced pelvic support after childbirth
- ☐ Trouble engaging pelvic floor during exercise

POSTPARTUM & POST-MENOPAUSE CHANGES

- ☐ Pelvic floor changes after pregnancy or delivery
- ☐ Vaginal laxity or decreased tone
- ☐ Menopause-related bladder changes
- ☐ Decline in pelvic muscle strength over time

QUALITY OF LIFE IMPACTS

- ☐ Fear of leakage during activities
- ☐ Avoiding exercise or social events
- ☐ Embarrassment or reduced confidence
- ☐ Impact on sleep due to nighttime urges
- ☐ Intimate wellness concerns

If yes, please elaborate (especially regarding intimate wellness concerns):

____

____

____

____

COGNITIVE HEALTH & MENTAL WELLNESS

COGNITIVE FUNCTION & FOCUS

- ☐ Difficulty concentrating
- ☐ Trouble maintaining focus on tasks
- ☐ Easily distracted
- ☐ Decreased productivity or mental clarity

MEMORY & RECALL

- ☐ Forgetfulness (short-term)
- ☐ Trouble recalling names or details
- ☐ Difficulty retaining new information
- ☐ "Brain fog" or clouded thinking

MOOD & EMOTIONAL WELL-BEING

- ☐ Persistent low mood
- ☐ Anxiety or nervousness
- ☐ Irritability or emotional ups/downs
- ☐ Stress that interferes with daily life

MENTAL ENERGY & MOTIVATION

- ☐ Feeling mentally drained
- ☐ Lack of motivation
- ☐ Difficulty starting tasks
- ☐ Slower thinking or processing speed
- ☐ Food noise / making better food choices
- ☐ Currently taking a GLP-1

SLEEP & RESTFULNESS

- ☐ Trouble falling asleep
- ☐ Frequent waking at night
- ☐ Waking unrefreshed
- ☐ Daytime drowsiness or fatigue

OVERALL QUALITY OF LIFE

- ☐ Reduced ability to perform daily tasks
- ☐ Impact on work or school performance
- ☐ Struggling with social or personal relationships
- ☐ Desire for improved cognitive balance

EXISTING DIAGNOSIS

- ☐ Diagnosed mental health condition
- ☐ Diagnosed neurological condition
- ☐ Diagnosed memory or cognitive condition

If yes, please elaborate:

____

____

____

IF YOU CHECK YES TO ANY OF THESE, A TEAM MEMBER FROM THE WELLNESS CENTER MAY BE IN CONTACT WITH YOU.

DIRECTIONS TO ATHLETIC ADVANTAGE

Athletic Advantage Physical Therapy ***A Myofascial Release and Wellness Center*** is located near the corner of Orange Road and Green Meadows Drive, In Lewis Center.
7844 Green Meadows Drive https://goo.gl/maps/RvdfUrfEBSqmSsTH7
Lewis Center, OH 43035

We are directly beside the Goldfish Swim School, West of the railroad tracks. You get to our office by turning onto the access road behind the Goldfish Swim School.

-From 23N, turn right on Orange Road, then right on Green Meadows Drive. Turn right on the access road just passed the Goldfish Swim School.

-From 71 and Polaris Drive, Turn North, right, onto South Old State Road. Go North to Orange Road and turn left, stay on Orange Rd until you cross the railroad tracks. Green Meadows is your First Left.

You will turn left just over the railroad tracks onto Green Meadows Drive. Immediately turn right onto the access road passed Goldfish Swim School.