beFIT
THERAPY

New Patient Registration

Name:_____

Address:_____

City:_____ State:_____ Zip code:_____

Primary telephone #:_____ Check one:☐ home ☐ work ☐ cell

Secondary telephone #:_____ Check one:☐ home ☐ work ☐ cell

Email:_____

Sex : Male☐ Female☐ Date of birth:_____

Referred by:_____ Check one:☐ physician☐ family☐ friend ☐co-worker

Emergency contact:_____

Phone:_____ Relationship:_____

List Medications:

Medical History

Previous surgical history:

Pain level: 0 no pain 1 2 3 4 5 6 7 8 9 10 severe pain

Pain type: (circle all that apply)
Dull Achy Sharp Constant Shooting/Radiating Intermittent

Does the pain wake you up at night? Yes No

What activities increase your symptoms?

What activities decrease your symptoms?

Circle all conditions that apply to your medical history

Cardiovascular
Heart attack High blood pressure High cholesterol Other

Neurological
Seizures Multiple Sclerosis Parkinson's Disease Stroke Other

Pulmonary
Emphysema Bronchitis Asthma Other

Endocrine
Diabetes Thyroid Disease Other

Infectious Disease
HIV Hepatitis Other

Gastrointestinal
Ulcer Crohn's Other

Oncologic
Cancer

Hemotologic
Anemia Sickle cell Other

Auto immune
Lupus Celiac Other