Fusion Performance LLC
609 West Johnson Ave
Chesire, CT 06408

Name: **Date of Birth**: **Phone #**:

Primary Care Physician:

Have you RECENTLY noted any of the following (check all that apply)?

☐ changes in appetite
☐ changes in bowel or bladder function
☐ difficulty with balance while walking
☐ difficulty swallowing
☐ dizziness/lightheadedness
☐ fever/chills/sweats
☐ headaches
☐ nausea/vomiting
☐ pain at night
☐ shortness of breath
☐ weakness/fatigue
☐ weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

☐ anemia
☐ asthma
☐ cancer (type)____________________
☐ chemical dependency (i.e., alcoholism)
☐ depression
☐ diabetes
☐ epilepsy
☐ heart disease
☐ high blood pressure
☐ kidney/liver problems
☐ lung problems
☐ multiple sclerosis
☐ osteoporosis
☐ pacemaker inserted
☐ Parkinson's disease
☐ rheumatoid arthritis
☐ stomach ulcers
☐ stroke
☐ thyroid problems
☐ other______________
☐ other______________

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you smoke? YES NO

Height:____________________ **Weight**: ___________________

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list current medications:_metropolol, gabapentin,atorvastatin,meloxicam, low dose aspirin

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? YES NO

Allergies: ____

Are you latex sensitive? YES NO

Please list previous surgeries and past physical therapy treatment, including dates:

What injury are you seeing us for today? Lower Back

What is your current level of pain? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst

What is your pain at worst? No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst

Patient Signature:____ **Date**:___________________