

## Patient Information (No-Fault)

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Birthdate: \_\_\_/\_\_\_/\_\_\_ Day Phone: \_\_\_\_\_ Evening Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Gender (circle): M / F Social Security #: \_\_\_\_\_ (Use signing parent's # if patient is minor under 19 yrs)  
Email Address: \_\_\_\_\_ Can we email appointment reminders & information? Yes / No  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### No-Fault Insurance Information

Insurance Company Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Date of Accident: \_\_\_/\_\_\_/\_\_\_ Policy #: \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_  
Case Manager: \_\_\_\_\_ Phone#: \_\_\_\_\_ Fax#: \_\_\_\_\_

### Secondary Insurance Information: (private insurance if claim is denied)

Insurance Company Name: \_\_\_\_\_ Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone#: \_\_\_\_\_  
ID#: \_\_\_\_\_ Group#: \_\_\_\_\_ Name of Insured Person: \_\_\_\_\_  
Relation: \_\_\_\_\_ SS#: \_\_\_\_\_ Insured Employer: \_\_\_\_\_  
Employer Address: \_\_\_\_\_

I give my permission to SportsFocus Physical Therapy, PC to Release information to my insurance company. I authorize payment directly to SportsFocus Physical Therapy, PC for treatment I receive.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
(Signature of Patient or Guardian if patient is under 19)

I agree I am primarily liable for all charges for services rendered by SportsFocus Physical Therapy, PC and agree to pay all amounts not paid by my insurance carrier(s) for any reason. If I am claiming coverage under No-Fault laws, I understand I am fully liable if such coverage is subsequently denied. I agree to supply private insurance information in anticipation of such a denial. If I am claiming coverage through an HMO ( such as IHA, Com Blue or Univera), I understand I am responsible for obtaining a valid referral prior to treatment if required and that treatment without such a referral will cause me to be personally liable for today's charged as well as future charges. I understand in the event amounts are not paid when due, I agree to pay all reasonable attorney's fees and collection costs you may incur to collect such past due amounts. If referred to collection, a fee of 30.333% of your outstanding balance over \$100 will be added to your account. For amounts less than \$100, 40% of the balance will be added to your account.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
(Signature of Patient or Guardian if patient is under 19)

I have been advised of SportsFocus Physical Therapy's **Notice of Privacy Practices Regarding Patient Health Information**. You may request a copy of this at any time.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Signature of Patient or Guardian if patient is under 19)

### **No-Fault Insurance**

You must be covered under No-Fault insurance if you were injured in a motor vehicle accident. We will, as a courtesy, bill your no-fault carrier. However, if they do not pay, you will be responsible for the charges. If you have a secondary insurance on which you wish to rely, we must be given that information at the time of your **first** visit. HMO companies often require approvals and have benefits with limited visits. There is no guarantee your private insurance will cover your no-fault charges. You should also be aware that if you fail to pursue a valid No-Fault claim, your personal insurance will probably not cover our charges.

If you are also under Chiropractic care for this injury, no-fault may not cover charges if treatment is given on the same day as Physical Therapy.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Signature of Patient or Guardian if patient is under 19)

### **Cancellation/No-Show Policy**

We request that you call as soon as possible if you are unable to make a scheduled appointment. We understand that there are many legitimate and unforeseeable reasons for being unable to attend a scheduled visit. Taking that into consideration, we will allow a total of 3 cancellations or no-shows during your physical therapy care before charging \$25 for each future cancellation or no-show.

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Signature of Patient or Guardian if patient is under 19)



# Patient Intake Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Approximate date of last physical: \_\_\_/\_\_\_/\_\_\_

**Which of the following factors contributed to you choosing SportsFocus? (Check all that apply)**

- Doctor recommended
- Doctor's assistant recommended
- List provided by doctor
- Previous patient recommended
- Friend recommended
- I am a previous patient
- Location
- Web site or internet search
- Ad in the phone book

Who can we thank? \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Date of follow-up visit: \_\_\_/\_\_\_/\_\_\_

**What is your work status? (Check all that apply)**

- Homemaker
- Not employed/Not seeking work
- On disability
- Retired
- Student
- Unable to work due to injury
- Unemployed seeking work
- Working
- Working, modified duty

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Please describe the physical requirements of your job. *For example: 30% of day sitting, 30% of day standing, 20% of day walking, 20% of day lifting boxes weighing between 10 and 20 pounds.*

What's the length of your typical work day? \_\_\_\_\_ hours Typical work week? \_\_\_\_\_ days

Did you have any limitation of function during normal daily activities before your present injury or onset of symptoms?  Yes  No

*If Yes, please describe those limitations:* \_\_\_\_\_

## History of Current Complaints

**Chief complaints: (Check all that apply)**

- Balance problems
- Difficulty walking
- Difficulty with daily activities
- Dizziness
- Falls / history of falls
- Fatigue / poor endurance
- Headache
- Impaired sensation
- Joint stiffness
- Joint swelling
- Muscle tenderness
- Muscle weakness

**Affected Side:**  Left  Right  Both

- Numbness
- Pain
- Problems breathing/shortness of breath
- Tingling
- Other 1 \_\_\_\_\_
- Other 2 \_\_\_\_\_

**If there is pain, specify type of pain: (Check all that apply)**

- Ankle pain
- Back pain
- Chest pain
- Elbow pain
- Foot pain
- Hand Pain
- Hip pain
- Jaw pain
- Knee pain
- Lower Extremity / Leg pain
- Neck pain
- Rib pain

- Shoulder pain
- Upper Extremity / Arm pain
- Wrist pain
- Other: \_\_\_\_\_

When did the current problem(s) begin? \_\_\_/\_\_\_/\_\_\_ Date of Injury: \_\_\_/\_\_\_/\_\_\_

*If there is no specific date or you cannot recall, how long have you had these complaints?* \_\_\_\_\_

Describe details of your injury or any activities that contributed to your current complaints: \_\_\_\_\_

How are you taking care of the current problem(s) now? \_\_\_\_\_

**Are you seeing anyone else for the problem(s)? (Check all that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acupuncturist       | <input type="checkbox"/> Nurse practitioner                                 | <input type="checkbox"/> Primary care physician      |
| <input type="checkbox"/> Athletic trainer    | <input type="checkbox"/> Obstetrician/gynecologist                          | <input type="checkbox"/> Psychiatry                  |
| <input type="checkbox"/> Cardiologist        | <input type="checkbox"/> Occupational therapist                             | <input type="checkbox"/> Psychologist                |
| <input type="checkbox"/> Chiropractor        | <input type="checkbox"/> Orthopedist  | <input type="checkbox"/> Rheumatologist              |
| <input type="checkbox"/> Dentist             | <input type="checkbox"/> Osteopath  | <input type="checkbox"/> Social Work                 |
| <input type="checkbox"/> Family practitioner | <input type="checkbox"/> Pediatrician                                       | <input type="checkbox"/> Speech-Language Pathologist |
| <input type="checkbox"/> Internist           | <input type="checkbox"/> Physiatrist (Physical Medicine and Rehabilitation) | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> Massage therapist   | <input type="checkbox"/> Physical therapist                                 |  |
| <input type="checkbox"/> Neurologist         | <input type="checkbox"/> Podiatrist   |  |
| <input type="checkbox"/> Neurosurgeon        |   |  |

**Previous Episode**

**Has this problem occurred before?**  Yes  No

*If Yes, did the problem(s) get better?*  Yes  No **Start Date:** \_\_\_/\_\_\_/\_\_\_ **End Date:** \_\_\_/\_\_\_/\_\_\_

**About how long did the problem(s) last?** \_\_\_\_\_  Day(s)  Week(s)  Month(s)  Year(s)

**Did you see anyone for the *previous episode*? (Check all that apply)**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Acupuncturist       | <input type="checkbox"/> Nurse practitioner                                 | <input type="checkbox"/> Primary care physician      |
| <input type="checkbox"/> Athletic trainer    | <input type="checkbox"/> Obstetrician/gynecologist                          | <input type="checkbox"/> Psychiatry                  |
| <input type="checkbox"/> Cardiologist        | <input type="checkbox"/> Occupational therapist                             | <input type="checkbox"/> Psychologist                |
| <input type="checkbox"/> Chiropractor        | <input type="checkbox"/> Orthopedist  | <input type="checkbox"/> Rheumatologist              |
| <input type="checkbox"/> Dentist             | <input type="checkbox"/> Osteopath  | <input type="checkbox"/> Social Work                 |
| <input type="checkbox"/> Family practitioner | <input type="checkbox"/> Pediatrician                                       | <input type="checkbox"/> Speech-Language Pathologist |
| <input type="checkbox"/> Internist           | <input type="checkbox"/> Physiatrist (Physical Medicine and Rehabilitation) | <input type="checkbox"/> Other: _____                |
| <input type="checkbox"/> Massage therapist   | <input type="checkbox"/> Physical therapist                                 |  |
| <input type="checkbox"/> Neurologist         | <input type="checkbox"/> Podiatrist   |  |
| <input type="checkbox"/> Neurosurgeon        |   |  |

**What else did you do for the previous problem(s)?** \_\_\_\_\_

**Hospitalization**

**Related/Recent Hospitalizations?**  Yes  No *If Yes, date of Hospitalization* \_\_\_/\_\_\_/\_\_\_

**Concerns/Interests**

**I am concerned about or have problems with: (Check all that apply)**

- |   |   |
|---|---|
| <input type="checkbox"/> Bed mobility   | <input type="checkbox"/> Performing sports, recreation, and play activities |
| <input type="checkbox"/> Climbing stairs  | <input type="checkbox"/> Reaching over head                                 |
| <input type="checkbox"/> Coordination   | <input type="checkbox"/> Repetitive movements of the hand, arm, shoulder    |
| <input type="checkbox"/> Difficulty with self care (such as bathing, dressing, toileting)               | <input type="checkbox"/> Sitting  |
| <input type="checkbox"/> Flexibility  | <input type="checkbox"/> Standing   |
| <input type="checkbox"/> Grasping objects lifting   | <input type="checkbox"/> Transfers (getting out of a chair, bed)            |
| <input type="checkbox"/> Performing home management (household chores, shopping, care of dependents)    | <input type="checkbox"/> Walking  |
| <input type="checkbox"/> Performing job responsibilities/community activities (work, school, volunteer) | <input type="checkbox"/> Writing/grasping items with hand(s)                |
|   | <input type="checkbox"/> Other: _____                                       |

**I feel in need of or have interest in (Check all that apply):**

Education  Exercise  Fitness  Prevention  Other: \_\_\_\_\_

**Associated Surgeries / Injection or Epidural**

**Associated Surgery 1 Date:** \_\_\_/\_\_\_/\_\_\_ **Associated Surgery 1:** \_\_\_\_\_

**Associated Surgery 2 Date:** \_\_\_/\_\_\_/\_\_\_ **Associated Surgery 2:** \_\_\_\_\_

**Associated Surgery 3 Date:** \_\_\_/\_\_\_/\_\_\_ **Associated Surgery 3:** \_\_\_\_\_

**Injection Date:** \_\_\_/\_\_\_/\_\_\_ **Epidural Date:** \_\_\_/\_\_\_/\_\_\_

## Medical Screening

Do you currently, or have you ever had any of the following problems? (Check all that apply)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Abdominal pain                      | <input type="checkbox"/> Foot pain/discoloration                    | <input type="checkbox"/> Prolonged fatigue                                      |
| <input type="checkbox"/> Anxiety                             | <input type="checkbox"/> Frequent heartburn or indigestion          | <input type="checkbox"/> Pulsating pain in body                                 |
| <input type="checkbox"/> Bowel problems                      | <input type="checkbox"/> Frequent or severe headaches               | <input type="checkbox"/> Seizures   |
| <input type="checkbox"/> Chest pain                          | <input type="checkbox"/> Hearing impairment                         | <input type="checkbox"/> Sexually transmitted disease                           |
| <input type="checkbox"/> Constant pain in body               | <input type="checkbox"/> Hearing problems                           | <input type="checkbox"/> Shortness of breath                                    |
| <input type="checkbox"/> Coordination problems               | <input type="checkbox"/> Heart palpitations                         | <input type="checkbox"/> Stress/tension   |
| <input type="checkbox"/> Cough                               | <input type="checkbox"/> Hoarseness or changes in speech            | <input type="checkbox"/> Ulcer  |
| <input type="checkbox"/> Depression                          | <input type="checkbox"/> Insomnia                                   | <input type="checkbox"/> Unusual lumps or growths                               |
| <input type="checkbox"/> Difficulty or changes in swallowing | <input type="checkbox"/> Joint pain, swelling, or redness           | <input type="checkbox"/> Unusual menstrual irregularities                       |
| <input type="checkbox"/> Difficulty sleeping                 | <input type="checkbox"/> Loss of appetite                           | <input type="checkbox"/> Urinary problems                                       |
| <input type="checkbox"/> Difficulty walking                  | <input type="checkbox"/> Loss of balance or falling                 | <input type="checkbox"/> Vision problems (i.e. blurred vision or loss of sight) |
| <input type="checkbox"/> Dizziness or blackouts              | <input type="checkbox"/> Loss of pleasure in things usually enjoyed | <input type="checkbox"/> Weakness in arms or legs                               |
| <input type="checkbox"/> Excessive thirst                    | <input type="checkbox"/> Nausea/vomiting                            | <input type="checkbox"/> Weight loss/gain                                       |
| <input type="checkbox"/> Fainting spells                     | <input type="checkbox"/> Numbness or changes in sensation           | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> Feeling downhearted or blue         | <input type="checkbox"/> Pain at night                              |   |
| <input type="checkbox"/> Fever/chills/sweats                 | <input type="checkbox"/> Pain or cramping in lower leg (calf)       |   |

Comments for above: \_\_\_\_\_

## Been Diagnosed

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Arthritis                                     | <input type="checkbox"/> Head injury  | <input type="checkbox"/> Osteoarthritis             |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Headaches  | <input type="checkbox"/> Osteoporosis               |
| <input type="checkbox"/> Blood disorders                               | <input type="checkbox"/> Heart Attack/MI                                    | <input type="checkbox"/> Parkinson disease          |
| <input type="checkbox"/> Broken bones/fractures                        | <input type="checkbox"/> Heart Disease                                      | <input type="checkbox"/> Peripheral Neuropathy      |
| <input type="checkbox"/> Cancer  | <input type="checkbox"/> Hearing impairment                                 | <input type="checkbox"/> Psychiatric Disorders      |
| <input type="checkbox"/> Circulation/vascular problems                 | <input type="checkbox"/> Hypercholesteremia                                 | <input type="checkbox"/> Repeated infections        |
| <input type="checkbox"/> COPD (chronic obstructive pulmonary disorder) | <input type="checkbox"/> Hypertension (high blood pressure)                 | <input type="checkbox"/> Seizures/epilepsy          |
| <input type="checkbox"/> Deep vein thrombosis / PE                     | <input type="checkbox"/> Infectious disease (e.g., tuberculosis, hepatitis) | <input type="checkbox"/> Spinal cord injury         |
| <input type="checkbox"/> Depression                                    | <input type="checkbox"/> Kidney problems                                    | <input type="checkbox"/> Skin diseases              |
| <input type="checkbox"/> Developmental or growth problems              | <input type="checkbox"/> Liver disease                                      | <input type="checkbox"/> Stomach problems/ulcers    |
| <input type="checkbox"/> Diabetes                                      | <input type="checkbox"/> Low back pain                                      | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Eating Disorder                               | <input type="checkbox"/> Low blood pressure                                 | <input type="checkbox"/> Thyroid problems           |
| <input type="checkbox"/> Emphysema                                     | <input type="checkbox"/> Multiple sclerosis                                 | <input type="checkbox"/> Vision impairment          |
| <input type="checkbox"/> Fibromyalgia                                  | <input type="checkbox"/> Muscular dystrophy                                 | <input type="checkbox"/> Other joint injuries _____ |
| <input type="checkbox"/> GERD (Gastro-Esophageal Reflux Disease)       | <input type="checkbox"/> Obesity  | <input type="checkbox"/> Other: _____               |

Comments for above: \_\_\_\_\_

Are you pregnant?  Yes  No  Unsure *If Yes, what is your due date: \_\_\_/\_\_\_/\_\_\_*

## Surgery

Have you ever had surgery?  Yes  No

Select which surgeries and enter the date: (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> ACL repair/reconstruction.....Date: ___/___/___                | <input type="checkbox"/> Hand surgery .....Date: ___/___/___                            |
| <input type="checkbox"/> Achilles tendon repair .....Date: ___/___/___                  | <input type="checkbox"/> Heart transplantation .....Date: ___/___/___                   |
| <input type="checkbox"/> Angioplasty .....Date: ___/___/___                             | <input type="checkbox"/> Hernia repair .....Date: ___/___/___                           |
| <input type="checkbox"/> Aortic valve surgery .....Date: ___/___/___                    | <input type="checkbox"/> Hysterectomy .....Date: ___/___/___                            |
| <input type="checkbox"/> Appendectomy .....Date: ___/___/___                            | <input type="checkbox"/> Joint replacement: Which joint? _____ Date: ___/___/___        |
| <input type="checkbox"/> Arthroscopic surgery: Which joint: _____ Date: ___/___/___     | <input type="checkbox"/> Kidney transplant .....Date: ___/___/___                       |
| <input type="checkbox"/> Arthroscopic examination: Which joint: _____ Date: ___/___/___ | <input type="checkbox"/> Lapband surgery .....Date: ___/___/___                         |
| <input type="checkbox"/> Back surgery .....Date: ___/___/___                            | <input type="checkbox"/> Liver transplant .....Date: ___/___/___                        |
| <input type="checkbox"/> Bone marrow transplant .....Date: ___/___/___                  | <input type="checkbox"/> Lobectomy .....Date: ___/___/___                               |
| <input type="checkbox"/> Bunionectomy .....Date: ___/___/___                            | <input type="checkbox"/> Lung surgery .....Date: ___/___/___                            |
| <input type="checkbox"/> Coronary artery bypass graft .....Date: ___/___/___            | <input type="checkbox"/> Lung transplant .....Date: ___/___/___                         |
| <input type="checkbox"/> Caesarian section .....Date: ___/___/___                       | <input type="checkbox"/> Lumpectomy .....Date: ___/___/___                              |
| <input type="checkbox"/> Cardiac catheterization .....Date: ___/___/___                 | <input type="checkbox"/> Mastectomy .....Date: ___/___/___                              |
| <input type="checkbox"/> Cardiac surgeries .....Date: ___/___/___                       | <input type="checkbox"/> Neck surgery .....Date: ___/___/___                            |
| <input type="checkbox"/> Carpal tunnel release .....Date: ___/___/___                   | <input type="checkbox"/> Pacemaker/Defibrillator insertion .....Date: ___/___/___       |
| <input type="checkbox"/> Cholecystectomy (gallbladder removed) .....Date: ___/___/___   | <input type="checkbox"/> Plastic surgery .....Date: ___/___/___                         |
| <input type="checkbox"/> Chondroplasty .....Date: ___/___/___                           | <input type="checkbox"/> Rotator cuff repair .....Date: ___/___/___                     |
| <input type="checkbox"/> Colon surgery .....Date: ___/___/___                           | <input type="checkbox"/> Splenectomy .....Date: ___/___/___                             |
| <input type="checkbox"/> Colostomy .....Date: ___/___/___                               | <input type="checkbox"/> Tracheostomy .....Date: ___/___/___                            |
| <input type="checkbox"/> Femoral popliteal bypass .....Date: ___/___/___                | <input type="checkbox"/> Transurethral Resection of the Prostate .....Date: ___/___/___ |
| <input type="checkbox"/> Gall bladder surgery .....Date: ___/___/___                    | <input type="checkbox"/> Other: _____ Date: ___/___/___                                 |
| <input type="checkbox"/> Gastric Bypass surgery .....Date: ___/___/___                  |   |

## Medications

Please list all Prescription medications: (or provide list for photocopy) \_\_\_\_\_

Please list all Non-prescription medications: \_\_\_\_\_

## Medical Tests

Within the last year, have you had any of the following tests? (Check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Angiogram          | <input type="checkbox"/> EEG (electroencephalogram)      | <input type="checkbox"/> Pap smear               |
| <input type="checkbox"/> Blood tests        | <input type="checkbox"/> EKG (electrocardiogram)         | <input type="checkbox"/> Pulmonary function test |
| <input type="checkbox"/> Bone scan          | <input type="checkbox"/> EMG (electromyogram)            | <input type="checkbox"/> Spinal tap              |
| <input type="checkbox"/> CT scan            | <input type="checkbox"/> Mammogram                       | <input type="checkbox"/> Urine tests             |
| <input type="checkbox"/> Colonoscopy        | <input type="checkbox"/> MRI                             | <input type="checkbox"/> X-rays                  |
| <input type="checkbox"/> Doppler ultrasound | <input type="checkbox"/> Myelogram                       | <input type="checkbox"/> Other: _____            |
| <input type="checkbox"/> Echocardiogram     | <input type="checkbox"/> NCV (nerve conduction velocity) |  |

If Yes, describe test results \_\_\_\_\_

## Allergies

List any allergies: \_\_\_\_\_

## General Health Status

Please rate your general health:  Excellent  Very Good  Good  Fair  Poor

Have you had any major life changes during past year?

(eg, new baby, job change, death of a family member):  Yes  No

## Tobacco

Do you smoke?  Yes  No

## Exercise

Do you exercise beyond normal daily activities and chores?  Yes  No

Physical activities: (Check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Aerobics                            | <input type="checkbox"/> Golf                                | <input type="checkbox"/> Travel                 |
| <input type="checkbox"/> Biking                              | <input type="checkbox"/> Outdoor activities (hiking camping) | <input type="checkbox"/> Walking                |
| <input type="checkbox"/> Boating (rowing, sailing, canoeing) | <input type="checkbox"/> Running, jogging                    | <input type="checkbox"/> Weightlifting          |
| <input type="checkbox"/> Bowling                             | <input type="checkbox"/> Skating                             | <input type="checkbox"/> Yoga, pilates, tai chi |
| <input type="checkbox"/> Cards, boardgames                   | <input type="checkbox"/> Swimming                            | <input type="checkbox"/> Other _____            |
| <input type="checkbox"/> Gardening, yard work                | <input type="checkbox"/> Team sports                         |   |

On average, how many days per week do you exercise or do physical activity? \_\_\_\_\_

On average, how many minutes do you spend doing the exercise or physical activity for each session: \_\_\_\_\_

## Weight Change

Have you experienced any recent weight change?  No  Increased  Decreased # of pounds: \_\_\_\_\_

Timeframe of weight change: \_\_\_\_\_  Day(s)  Week(s)  Month(s)  Year(s)