



N. Asheville/Woodfin office
 2 Weaverville Road, St. 101
 Woodfin, NC 28804
 Phone: 828-424-9290
 Fax: 828-417-7103

Patient Information

****Please provide your Drivers License, Insurance Card(s) and Prescription**

Legal Name	Preferred Name	
Pronouns	Are you vaccinated for Covid 19? Yes. no.	
Street		
City, State, Zip		
Phone Number	Cell	Home
Can we text you?	If not, please provide email below.	
Date of Birth, age		
Occupation		
Referring Doctor		
E-mail Address		
Emergency contact	relationship:	Best number to reach:

We use email to communicate with our patients regarding their appointments, follow-up and billing. Your address will not be used by or sold to any 3rd party.

Payment Options

Primary insurance	
Secondary insurance	
Self payment option	
Do you have a prescription for therapy?	
Have you had PT in the current year?	

How did you find your way to BodyLogic? Please check and offer details.

Doctor (who)	On-line	Friend/family referral	Other

What is the **main condition(s)** you would like to be helped with?

Do you know how your issue happened? (injury, fall, sporting activity etc)

When did your symptom(s) begin? (approximate date)

Can you relieve your pain with **movement, rest** or **activity**?

What can you not do because of this issue?

What kinds of treatment have you tried for this issue? (PT, Chirop, Massage, Acupuncture, Ice Heat)

Diagnostic Work up:

Results

MRI	
Radiograph (X-Ray)	
Bone Density Scan (Dexa)	
Other:	
MEDICAL CONDITONS	MEDICATIONS YOU TAKE

Medical conditions that you have and medications you take for this?

Circle any that apply:

History of Cancer	Rheumatoid Arthritis	Balance issues	Chest pain with exertion
unexplained weight loss	Osteoporosis	History of Fainting	Kidney issues
Unexplained fever/chills	Osteopenia	Neuropathies	Diabetes
Night sweats	Dizziness	Seizures	High blood pressure
Pain worse at night	Lightheadedness	leg pain with exertion	immunosuppression
Change in bowel and bladder control	Noticeable, unexplained weakness of arms or legs	shortness of breath	recent falling

OTHER _____

Please tell us about activity that you do in your life (working, home, physically active).
Please describe the levels of stress in your life.
How does stress impact you and how do you deal with stress?
During the past month, have you often been bothered by feeling down, depressed, or hopeless? NO YES
During the past month, have you often been bothered by little interest or pleasure in doing things? NO YES
Is this something with which you would like help? NO YES

Patient Signature: _____

Date: _____