

Face Sheet Physical Therapy & Wellness Strength & Conditioning

Client Contact Info	If necessary, ProActFit would like your permission to contact your PCP - Primary Care Physician . Please leave info below if ProActFit may contact your PCP.
Name: Date	Physician Information
Address:	
	Primary Care Physician (PCP):
Date of Birth:	
Email:	
Phone cell#:	PCP Address:
Phone other#:	PCP Phone:
Job Title:	PCP Email:
	PCP Fax:
Are you seeing any specialists for any condition? yes no Please circle below, if applicable.	If yes, to specialist please provide information regarding condition.
Cardiologist Neurologist Rheumatologist	
Podiatrist Surgeon Primary Care Physician	
Chiropractor Acupuncturist Massage Therapist	Please provide a list of any medications/supplements
Alternative Medicine / Other:	
	W. W. L
Emergency Contact:	Health Insurance Carrier: (If applicable for reimbursement)
Name:	Phone:
Phone:	Claim contact number may be found on the back of insur card.
I attest that the above information is true and correct to the best of my knowledge. I give ProActFit's owner's and contractors permission to contact the above emergency contact(s) for the interest of my health or in case of emergency. I also fully understand that I am 100% responsible for the payments due for my sessions with ProActFit, LLC - Physical Therapy & Wellness / Strength & Conditioning. I understand that ProActFit is not an insurance provider for any claims.	
Name (Print) Name	/ Signature Date