PATIENT INFORMATION

PLEASE COMPLETE THIS FORM COMPLETELY

Patient Name _____ **Date of Birth** ____/____/____ **Sex** F ___ M ___

Marital Status □ Single □ Married □ Divorced □ Widowed

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone_____ **Cell** _____ **Email**_____

Primary Physician_____ **Phone**_____

Referring Physician_____ **Phone**_____

Employer_____ **Occupation**_____ **Phone**_____

Emergency Contact_____ **Phone**_____

How did you hear about our clinic? _____

MEDICAL HISTORY:

• What is the problem you are here for_____

• Date of injury or when pain started:_____ • Date of Surgery (if applicable):_____

Check which apply to your injury:

□ Work-related
□ Athletic / recreational injury
□ Recurrence of previous injury
□ Cause unknown
□ Motor vehicle accident
□ Injury related to lifting or falling
□ Other:_____

• Is this the first time you have had this pain? Y N If NO, then when:_____

• What treatments have you tried? □Medications □Physical Therapy □Massage □Chiropractic □Injection

• What Tests/Procedures have been done for your current condition:

□X-Rays □MRI/CT Scan □Bone Scan □EMG □Blood Work □Other_____

• Do you have any ***allergies***? Y N If yes, please list

_____

• Are you presently taking any ***medication***? Y N If yes, please list what medication and for what condition_____

_____

Please list ***surgeries*** or other conditions for which you have been ***hospitalized***

_____

_____

PAIN AND SYMPTOMS:

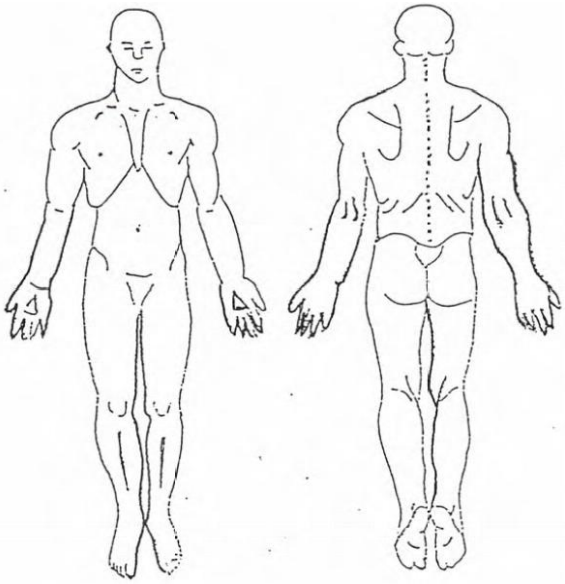
Please check the answers that apply to you:

• Is your pain? Continuous Frequent Occasional

• What makes your pain ***better***? sitting □sleeping □walking □laying flat □bending forward □bending backward □standing in one place □other:_____

• What makes your pain ***worse***? □sitting □sleeping □walking □laying flat □driving □bending forward/backward □reaching above your head □walking up/down stairs □other:_____

Please indicate below where your symptoms are located:



• Circle the number that rates **your pain *right now***:

None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

• Circle the number that rates **your pain *at worst:***

None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

• Circle the number that rates **your pain *at best:***

None 1 2 3 4 5 6 7 8 9 10 Go to the hospital

KEY	
NUMBNESS	**++++++**
PINS & NEEDLES	**ooooooo**
BURNING PAIN	**XXXXX**
STABBING PAIN	**//////////**
ACHE	**!!!!!!!!!!**

Please check "yes" if you have ever been diagnosed with…

Auto-Immune Disease	**YES**	**NO**
Systemic Arthritis (RA, Lupus, Other)	□	□
Unexplained rashes, sores or swelling	□	□
Fibromyalgia/ Chronic Fatigue	□	□
Blood Disorders	**YES**	**NO**
Bleeding disorders	□	□
Clotting disorders	□	□
History DVT (Blood Clots)	□	□
Peripheral vascular disease	□	□
Cardiac	**YES**	**NO**
Heart Attack	□	□
Chest pain or Angina	□	□
Heart Disease	□	□
Fainting	□	□
Pacemaker	□	□
High Blood Pressure	□	□
Endocrine/Metabolic	**YES**	**NO**
Diabetes	□	□
Kidney or Liver Disease	□	□
Osteoporosis	□	□
Immunologic	**YES**	**NO**
HIV	□	□

Neurologic	**YES**	**NO**
Stroke/TIA	□	□
Muscular Sclerosis	□	□
Parkinson's Disease	□	□
Seizure disorder	□	□
Poor balance with frequent falls	□	□
Recent tremors or clumsy walking	□	□
Depression/Anxiety	□	□
Cancer	□	□
Currently pregnant (or think you might be)	□	□
Vision or hearing difficulties	□	□
Bowel/Bladder abnormalities	□	□
Headaches/Migraines	□	□
Do you have metal implants	□	□
Pulmonary	**YES**	**NO**
COPD	□	□
Severe fatigue/malaise	□	□
Shortness of Breath	□	□
Cystic fibrosis	□	□
Asthma	□	□
Chronic bronchitis	□	□
Emphysema	□	□

Note: If you are unsure about a particular item, please leave it blank and discuss this with your therapist

• If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history and recent hospitalizations.

_____

_____

Patient/Parent/Legal Guardian Signature_____ Date _____