**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referring Provider** (if any)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Care Physician or Pediatrician**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Area of Discomfort that brings you to Therapy**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How long have you had this problem?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_

**Goal(s) in Therapy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you consulted any other health care professionals for this problem before?** *(check all that apply):*

⬜ Primary Care Physician ⬜ Orthopedic Specialist ⬜ Neurologist ⬜ Chiropractor

⬜ Massage Therapist ⬜ Acupuncturist ⬜ Physical Therapist ⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Recent Diagnostic Imaging or Laboratory Work done:** *(check all that apply):*

⬜ X-Ray ⬜ MRI ⬜ CT-scan ⬜ Bloodwork ⬜ Urinalysis ⬜ Doppler/Ultrasound

⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*Please check all that apply to your work*:

⬜ Prolonged sitting ⬜ Prolonged standing ⬜ Use of heavy equipment

⬜ Lifting/Bending Twisting ⬜ Repetitive movements ⬜ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If unemployed or retired, previous employment:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Tobacco Use**  Do you smoke cigarettes? Yes No  If so, how many per day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How long have you been smoking?\_\_\_\_\_\_\_\_\_\_\_ | **Female Patients: Pregnancy**  Are you pregnant? Yes No  Is there any chance you may be pregnant? Yes No |

|  |  |
| --- | --- |
| **Please rate your *current* pain level**:  0 (no pain) - 10 (worst pain imaginable):  \_\_\_\_ / 10 |  |
| Please rate your *lowest* pain level in the past 24 hours  \_\_\_\_/ 10 |
| Please rate your *highest* pain level in the past 24 hours  \_\_\_\_ / 10 |
| Using the diagram to the right, please indicate the areas  where you are experiencing pain. The symbols below can be used as descriptors.  Numbness 00000  Pins/needles ////////  Burning ^^^^^  Aching XXXXX  Stabbing \*\*\*\*\*\*\* |

**Current Medical Symptoms *(Please check if you are currently having any of the following…)***

⬜ Fever/chills/sweats (day or night) ⬜ Nausea/vomiting/loss of appetite

⬜ Unexplained weight loss or gain ⬜ Changes in bowel or bladder function

⬜ Unusual fatigue/drowsiness ⬜ Numbness or tingling

⬜ Sudden weakness ⬜ Trouble sleeping

⬜ Confusion/memory loss ⬜ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History**

**Please list any surgeries you have had and the date(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Medications**

**Please list all prescription and over the counter medications you are currently taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Other Medical History: *(please check all that apply in the past or present)***

⬜ Diabetes ⬜ Autoimmune Disease ⬜ Anxiety/Depression

⬜ High Blood Pressure ⬜ Lupus ⬜ Infectious Disease

⬜ Heart Disease ⬜ Sjogren’s Syndrome ⬜ Allergies (latex, adhesive, drug, etc)\_\_\_\_\_\_\_\_\_\_\_

⬜ Heart Attack ⬜ Celiac Disease ⬜ Hernia

⬜ Stroke ⬜ Shortness of breath/Asthma ⬜ Metal Implant

⬜ Pacemaker ⬜ Abnormal Bleeding ⬜ Bladder/Incontinence

⬜ Seizures ⬜ Cancer – (what type:) \_\_\_\_\_\_\_\_ ⬜ Bowel/Rectal issues

⬜ Rhematoid Arthritis ⬜ Neurologic Disorder ⬜ Kidney Problems

⬜ Oseteoarthritis ⬜ Psychological treatment ⬜ Drug/Alcohol Abuse

⬜ Difficulty Sleeping ⬜ Balance Problems ⬜ Deep Vein Thrombosis/Blood clots

⬜ Fibromyalgia ⬜ Head Injury ⬜ Hearing or Vision Loss/Disturbance

⬜ Hepatitis A,B,C ⬜ Multiple Sclerosis ⬜ Vision problems

⬜ Thyroid Condition ⬜ Shingles/Skin Disease ⬜ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_