

Patient's Name (First, Middle, Last) **Home Therapy:** Are you currently receiving health care services in your home that are billed to your insurance? Yes No

EMAIL: (for exercise program):

Other Treatment: Have you received any of these treatments this year? Physical /Occupational / Speech Therapy
 Chiropractic/Spinal Manipulation OMM (Osteopathic Manipulative Medicine)

Reason for Visit (Describe Injury): Goal (What do you want to do better with therapy?): Date of Onset:

Onset/Timing: Number of Prior Episodes: Gradual Onset Sudden Onset

How did your pain/problem start? Unknown While Lifting Car Accident A Fall
 Trauma Overuse Degenerative Process Recreation/Sport: Dental Appt
 Other:

Severity of pain/problem: Improving Not Changing Worse
Current Pain: ___/10 **Highest pain in past 2 weeks:** ___/10 **Lowest pain in past 2 weeks:** ___/10

Pain is: Constant Intermittent Variable in Intensity Activity Dependent

Describe your pain/symptoms: Sharp Dull Throbbing Aching
 Periodic Occasional Constant Painful/Stiff when getting out of bed
 Other:

Throughout the day, my pain/problem: Increases Decreases Stays the same

Wake up at night when: Lying still changing positions lying still and changing positions

Sleeping Position: Back, sides and stomach on right side on left side
 on stomach on back chair/recliner

Within the past year, have you had any of the following symptoms? (check all that apply)

<input type="checkbox"/> Unable to control bowel/bladder	<input type="checkbox"/> Fever/Chills	<input type="checkbox"/> Numbness of Genitalia	<input type="checkbox"/> Numbness
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Unexplained Weakness	<input type="checkbox"/> Unexplained change in weight	<input type="checkbox"/> Night Pain/Sweats
<input type="checkbox"/> Malaise	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Hearing Problems	
<input type="checkbox"/> Other:			

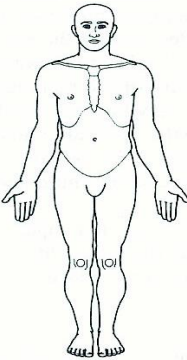
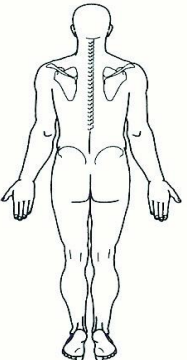
Aggravating Factors (check all that apply):

<input type="checkbox"/> Sitting	<input type="checkbox"/> Going to/raising from sitting	<input type="checkbox"/> Walking	<input type="checkbox"/> Up/Down Stairs	<input type="checkbox"/> Lying Down
<input type="checkbox"/> Looking Up Overhead	<input type="checkbox"/> Reach Overhead	<input type="checkbox"/> Reach In Front	<input type="checkbox"/> Reach Behind Back	<input type="checkbox"/> Reach Across Body
<input type="checkbox"/> Repetitive Activity	<input type="checkbox"/> Household Activities	<input type="checkbox"/> Sports/Recreation	<input type="checkbox"/> Standing	<input type="checkbox"/> Squatting
<input type="checkbox"/> Sustained Bending	<input type="checkbox"/> Cough	<input type="checkbox"/> Deep Breathing	<input type="checkbox"/> Sleeping	<input type="checkbox"/> Talking
<input type="checkbox"/> Chewing	<input type="checkbox"/> Swallowing	<input type="checkbox"/> Yawning	<input type="checkbox"/> Stress	
<input type="checkbox"/> Other:				

Alleviating Factors (check all that apply):

<input type="checkbox"/> Rest	<input type="checkbox"/> Cold	<input type="checkbox"/> Heat	<input type="checkbox"/> Medication	<input type="checkbox"/> Wearing a splint/orthotics
<input type="checkbox"/> Walking	<input type="checkbox"/> Lying Down	<input type="checkbox"/> Stretching	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing
<input type="checkbox"/> Other:			<input type="checkbox"/> Exercise	<input type="checkbox"/> Massage

Please map your areas of discomfort or altered sensation on the body map.
XXX = Pain
000 = Numb/Tingle/Radiating
*** = Weakness

MEDICAL/SURGICAL HISTORY: a. Please check all that apply

<input type="checkbox"/> ADD	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Orthotics
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Falls	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Allergies/Hayfever	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Lymphedema	<input type="checkbox"/> Peripheral Vascular
<input type="checkbox"/> Ankle Sprains	<input type="checkbox"/> Cancer	<input type="checkbox"/> Fracture	<input type="checkbox"/> Neurological Disorder	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Ankylosing spondylitis	<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Serious Illness/Injury
<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Headaches	<input type="checkbox"/> Meniere's Disease	<input type="checkbox"/> Skin Sensitivities
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Muscle/Bone Problem	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hernia	<input type="checkbox"/> Neck Injury	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> Surgery History: <i>(please list & include dates (mo/year):</i>			<input type="checkbox"/> Obesity	<input type="checkbox"/> Vertigo

MEDICATIONS: Do you take prescription or nonprescription medication? YES, NO If yes, please list below or attach a list.

Prescription	Non-prescription
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ALLERGIES: Do you have any allergies? None Bees Latex Perfumes/lotions Coconut pine/linden
 Adhesive/tapes Other *(please specify):*

(We use various emollients and tapes, please feel free discuss ingredients with therapists.)

SOCIAL HISTORY:

Smoking Status: Never Former Current Everyday Current Some Day Smoker – Status Unknown

Employment/Work (job/school) Full time Part time Retired Student Unemployed Disability

Occupation: _____ Sports/Hobbies: _____

Exercise Level: None Occasional Moderate Heavy
(Please include type of exercise, days/wk, and average # minutes)

Marital Status: Unknown Married Single Divorced Separated Widowed Domestic Partner # of Children: _____

Living Status: Alone Live with others Pet(s): *(please specify)*

Single/Multi-level home/work: Single-level home Multi-level home Single-level work Multi-level work

Work Related Injury: Yes No Auto Related Injury: Yes No

Able to care for self: Yes No *(if no, who cares for you?)*

Patient signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____