Name: _____

DOB: _____

Today's Date: _____

Current Condition:

Describe the problem(s) for which you seek Physical Therapy/Acupuncture/Massage:_____
_____
_____
_____
When did it begin:_____
What happened_____
_____
_____
Have you ever had this problem before? ☐ Yes ☐ No
How did you treat the problem?_____
_____
Did the problem get better? ☐ Yes ☐ No
How long did it last_____
What are you doing to care for this problem_____
_____
What makes the problem worse_____
_____
What makes the problem better_____
_____
What are your goals from treatment_____
_____
Have you seen other health care providers for this problem
_____
_____

Please **circle** below to rate the intensity of your pain *

At its lowest: 0 1 2 3 4 5 6 7 8 9 10

At its highest: 0 1 2 3 4 5 6 7 8 9 10

Right now: 0 1 2 3 4 5 6 7 8 9 10

* **Please see pain scale attached to the clipboard** *

Have you had any major changes in the last year?
(i.e. Job change, death in family, etc)
☐ Yes ☐ No

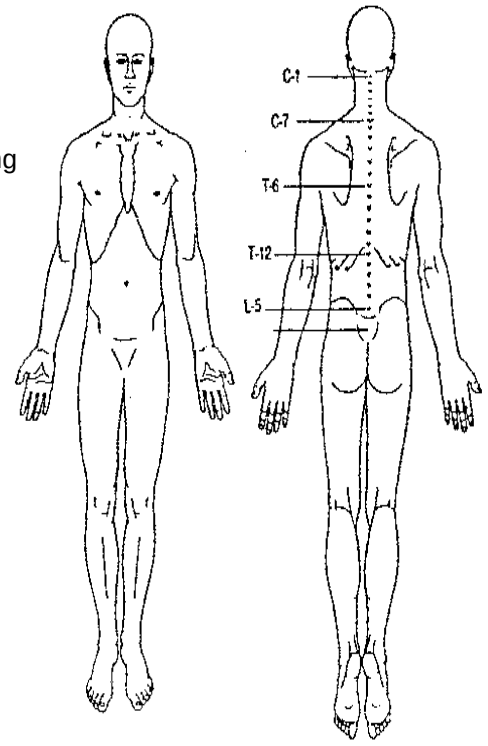
General Health
Please rate your general health

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please mark body area with an:

"X"
for pain/discomfort

"O"
for numbness/tingling



HEIGHT:

_____ ' _____ "

WEIGHT:

_____ **lbs**

Social/Health Habits

Smoking
Are you currently using tobacco? ☐ Yes ☐ No
_____Cigarettes/Cigars per day
Did you smoke in the past ☐ Yes ☐ No (yr quit_____)

Alcohol
Days per week you consume alcohol_____
Number of alcoholic drinks per day_____

Exercise
Do you exercise beyond daily activities and chores?
☐ No ☐Yes How many days per week_____
Describe the exercise_____
_____

Within the past year, have you had any of the following:

☐ Chest Pain
☐ Heart Palpitations
☐ Hoarseness
☐ Shortness of Breath
☐ Dizziness/Blackouts
☐ Coordination Problems
☐ Weakness in Arms or Legs
☐ Falls/Loss of Balance
☐ Difficulty Walking
☐ Joint Pain or Swelling
☐ Pain at Night
☐ Difficulty Sleeping
☐ Loss of Appetite
☐ Nausea/Vomiting
☐ Bowel Problems
☐ Weight Loss/Gain
☐ Urinary Problems
☐ Fever/Chills
☐ Headaches
☐ Migraines
☐ Hearing Problems
☐ Vision Problems
☐ Other:
_____

Name: _____

DOB: _____

Today's Date: _____

Medical History
Please check if you have ever had the following:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Asthma
- ☐ Auto Immune Disorder
- ☐ Blood Disorders
- ☐ Broken Bones
- ☐ Cancer _____
- ☐ Circulation Problems
- ☐ Diabetes
- ☐ Developmental Problems
- ☐ Emotional Problems
- ☐ Fibroids
- ☐ Gastric Reflux
- ☐ Head Injury
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infectious Disease
- ☐ Infertility
- ☐ Insomnia
- ☐ Kidney Problems
- ☐ Ankylosing Spondy
- ☐ Low Blood Pressure
- ☐ Spondylolisthesis
- ☐ Low Blood Sugar
- ☐ Lung Problems
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Parkinson Disease
- ☐ Prostatisis
- ☐ Shingles
- ☐ Skin Disease
- ☐ Seizures/Epilepsy
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Urinary leakage
- ☐ Urinary difficulty
- ☐

Family Health
Indicate whether any family member has had the following, and date of onset, if known:

- ☐ Heart Disease _____
- ☐ Hypertension _____
- ☐ Stroke _____
- ☐ Diabetes _____
- ☐ Cancer _____
- ☐ Psychological _____
- ☐ Arthritis _____
- ☐ Osteoporosis _____

Please List Type and Date of Surgeries, Epidural Blocks or Trigger Point Injections: Month Year

_____ ☐☐ ☐☐
_____ ☐☐ ☐☐
_____ ☐☐ ☐☐
_____ ☐☐ ☐☐
_____ ☐☐ ☐☐

Other Diagnostic Tests
Within the past year, have you had any of the following tests?

- ☐ Angiogram
- ☐ Arthroscopy
- ☐ Biopsy
- ☐ Blood Tests
- ☐ Bone Scan
- ☐ Bronchoscopy
- ☐ CT Scan
- ☐ Doppler ultrasound
- ☐ Echocardiogram
- ☐ EEG
- ☐ EKG
- ☐ EMG
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ NCV
- ☐ Pap Smear
- ☐ Pulmonary Function
- ☐ Spinal tap
- ☐ Stool Test
- ☐ Stress Test
- ☐ Urine Test
- ☐ X-ray
- ☐ Other _____

Mental Health
Over the last 2 weeks, how often have you been bothered by any of the following:

Little interest or pleasure in doing things?
Not at all – 0
Several Days – 1
More than half the days – 2
Nearly every day – 3

Feeling down, depressed or hopeless?
Not at all – 0
Several Days – 1
More than half the days – 2
Nearly every day – 3

Have you ever been diagnosed with Depression, Anxiety, Bi-Polar or other? ☐ Yes ☐ No

_____
_____
_____

Are you currently taking medication for your Diagnosis?
☐ Yes ☐ No

Women Only: Have you been diagnosed with:

- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Trouble with your period
- ☐ Pregnancy Complications
- ☐ Pregnant or might be pregnant
- ☐ Other OB/GYN difficulties
- ☐ Pregnancy & Deliveries_____

Acupuncture
Have you ever had acupuncture?
☐ Yes ☐ No
Are you currently taking blood thinners?
☐ Yes ☐ No
Questions regarding acupuncture_____
_____
_____

Name:_____

Date of Birth: _____-_____-_____

Today's Date: _____-_____-_____

Please list all medications you are currently taking. Include all prescriptions, over-the-counters, herbals, vitamin/mineral and dietary (nutritional) supplements with the dosage, frequency, route of administration and reason for medication.

Medication Name	Dosage	Frequency	Route	Prescribed for	Start / Stop of Medication & Date	Date / Initial by PT, Lac, MT
Example: Aspirin	**81 mg**	**1 x day**	**Mouth**	**blood thinner**	**Started 1/1/12**	**Office use only**

LIST ANY ALLERGIES / SENSITIVITIES: (medications, latex, lotion, cream etc.)

_____

_____

_____

_____

_____

_____

_____

_____