

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Injury \_\_\_\_\_ Insurance ID# \_\_\_\_\_

**A. Patient Information**

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_

Work \_\_\_\_\_ Cell/Pgr \_\_\_\_\_

Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone: Home \_\_\_\_\_

Work \_\_\_\_\_ Cell/Pgr \_\_\_\_\_

**Primary Health Care Provider**

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax \_\_\_\_\_

I give my manual therapist permission to consult with my referring health care provider regarding my health and treatment.

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_\_

**B. Current Health Information**

List Health/Concerns Check all that apply

Primary \_\_\_\_\_

mild  moderate  disabling

constant  intermittent

symptoms ↑ w/activity  ↓ w/activity

getting worse  getting better  no change treatment received \_\_\_\_\_

Secondary \_\_\_\_\_

mild  moderate  disabling

constant  intermittent

symptoms ↑ w/activity  ↓ w/activity

getting worse  getting better  no change treatment received \_\_\_\_\_

Additional \_\_\_\_\_

mild  moderate  disabling

constant  intermittent

symptoms ↑ w/activity  ↓ w/activity

getting worse  getting better  no change treatment received \_\_\_\_\_

Have you ever received Manual Therapy before?  Y  N Frequency? \_\_\_\_\_

List all conditions currently monitored by a Health Care Provider \_\_\_\_\_

List the medications you took today (include pain relievers and herbal remedies)

List all other medications taken in the last 3 months \_\_\_\_\_

**List Daily Activities**

Work \_\_\_\_\_

Home/Family \_\_\_\_\_

Social/Recreational \_\_\_\_\_

Circle the activities affected by your condition,  all of the above

Check other activities affected:  sleep

washing  dressing  fitness

How do you reduce stress? \_\_\_\_\_

Pain? \_\_\_\_\_

What are your goals for receiving Manual Therapy? \_\_\_\_\_

**C. Health History**

List and Explain. Include dates and treatment received.

Surgeries \_\_\_\_\_

Accidents \_\_\_\_\_

Major Illnesses \_\_\_\_\_