THERAWORX
STAY MOBILE

PATIENT PROFILE

Today's Date: ____/____/_____

Name:(First,Last) _____

Preferred Name:_____

Address: _____ City: _____ State: _____

Zip: _____ Date of Birth: _____ Gender: ( ) Male ( ) Female

Home: _____ Mobile: _____ Work: _____

Email: _____

Preferred Method of Contact: ( ) Email ( ) Phone - Home, Mobile, or Work

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Other

Employed: ( ) No ( ) Yes (Occupation)_____

RACE & ETHNICITY

( ) African American or Black
( ) American Indian or Alaskan Native
( ) Asian
( ) Hispanic or Latino
( ) Native Hawaiian or Other Pacific Islander
( ) White
( ) Decline

PREFERRED LANGUAGE

( ) English
( ) Spanish
( ) Other: _____

EMERGENCY CONTACT INFORMATION

Name: _____
Home: _____
Mobile: _____
Relationship:
( ) Child ( ) Parent ( ) Spouse ( ) Other: _____

MEDICAL HISTORY

Have you ever had any of the following? (Please select all that apply)

Illnesses:
( ) Asthma
( ) Autoimmune Disorder (Type) _____
( ) Blood Clots
( ) Cancer (Type) _____
( ) CVA/TIA(stroke)
( ) Diabetes
( ) MigraineHeadaches
( ) Osteoporosis
( ) Other:_____

Injuries:
( ) Back Injury
( ) Broken Bones
( ) Head Injury
( ) Neck Injury
( ) Falls: # last 6 mo _____
( ) Hospitalizations: 1 yr _____
( ) Other:_____

Surgeries: (provide type & surgery date)
( ) Orthopedic
- Shoulder – R / L _____
- Elbow/Forearm – R / L _____
- Wrist/Hand – R / L _____
- Hip – R / L _____
- Knee – R / L _____
- Ankle/Foot – R / L _____

( ) Spinal Surgery
- Neck: _____
- Back: _____

( ) Other: _____

Family Medical History: (heart disease, cancer, stroke, diabetes, autoimmune, arthritic, etc.)
_____
_____
_____

Current or Recent Medication: (have taken or take on a regular basis)
_____
_____
_____

REVIEW OF SYSTEMS

Are you currently experiencing any of these symptoms? (Please select all that apply)

Constitutional: (General)
( ) Fever
( ) Fatigue
( ) Other:_____

Respiratory:
( ) Difficulty Breathing
( ) Cough
( ) Other:_____

Cardiovascular & Heart:
( ) ChestPains/Tightness
( ) Rapid or Heartbeat Changes
( ) Swelling of Hands, Ankles, or Feet
( ) Other: _____

Musculoskeletal:
( ) Joint Pain/Stiffness/Swelling
( ) Muscle Pain/Stiffness/Spasms
( ) Broken Bones_____

Neurological:
( ) Dizziness or Lightheaded
( ) Convulsions or Seizures
( ) Tremors
( ) Other:_____

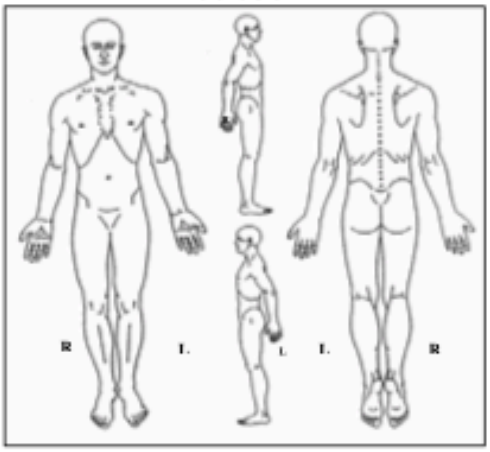
HISTORY OF PRESENT ILLNESS

Major Complaint:_____
Secondary Complaints:_____
When did it start? ____/____/_____ What occurred?_____
Which daily activities are being affected by this condition?_____

MAJOR COMPLAINT:

PLEASE MARK ANY SYMPTOMS ON THE DIAGRAM

Location of Symptoms and Radiation



P: Pain **T:** Tender
N: Numb **H:** Hypoesthesia
S: Spasm

Grade Intensity/Severity:

- ☐ None (0/10)
- ☐ Mild (1-2/10)
- ☐ Mild-Moderate (2-4/10)
- ☐ Moderate (4-6/10)
- ☐ Moderate-Severe (6-8/10)
- ☐ Severe (8-10/10)

Frequency:

- ☐ Off & On
- ☐ Constant

Quality:

- ☐ Sharp
- ☐ Stabbing
- ☐ Burning
- ☐ Achy
- ☐ Dull
- ☐ Stiff & Sore
- ☐ Other: _____

Does it radiate?

☐ No ☐ Yes *(Please indicate on drawing)*

Improves with:

- ☐ Ice
- ☐ Heat
- ☐ Movement
- ☐ Stretching
- ☐ OTC Medications: _____
- ☐ Other: _____

Worsens with:

- ☐ Sitting
- ☐ Standing/Walking
- ☐ Lying Down/Sleeping
- ☐ Overuse/Lifting
- ☐ Other: _____

Previous Treatment:

- ☐ None
- ☐ Chiropractor _____
- ☐ Medical Doctor _____
- ☐ Physical Therapy _____
- ☐ ER/Urgent Care _____
- ☐ Orthopedic _____
- ☐ Other: _____

Previous Diagnostic Testing:

- ☐ None
- ☐ X-rays _____
- ☐ MRI _____
- ☐ CT _____
- ☐ Other: _____

Women:** ***Are you pregnant?

☐ No
☐ Yes *Due date:* ___/___/____

Prescription Medications & Supplements:

☐ None
☐ Yes *(List – Name, dosage, frequency):*

_____

_____

Present Illness Comments:_____

I have answered the questions on the Patient Profile, Medical History, and History of Present Illness forms to the best of my knowledge and certify them to be true and correct.

Patient Signature_____
Date_____