THREE PEAKS
PHYSICAL THERAPY, MASSAGE
& ACUPUNCTURE

PATIENT INFORMATION

Patient Contact / Personal information

Name: _____

Please circle Male Female Date of Birth: _____ Social Security #: _____

Address: _____ City: _____ Zip: _____

Mailing address (if different): _____

Phone with area code: Home: _____ Work: _____ Cell: _____

Please circle preferred form on contact; if texting is acceptable, please circle Yes No

e-mail (optional): _____

How did you hear about us: _____

Emergency contact / Patient's guardian information (as applicable)

Name: _____

Relation: _____ Spouse's Social Security # if this visit is for insurance: _____

Address: _____ City: _____ Zip: _____

Phone with area code: Home: _____ Work: _____ Cell: _____

Employer information (if this is an insurance case)

Occupation: _____ Employer: _____

Address: _____ City: _____ Zip: _____

Reason for this visit

Please check which issues affect you currently: Current pain scale (0 being pain free, 10 worst pain imaginable): _____

Part of the body you have issue with	Pain	Stiffness	Weakness	Difficulty of movement	Numbness and/or tingling	Other
Head						
Neck						
Shoulders						
Upper arms (left or right)						
Elbows (left or right)						
Fore arms (left or right)						
Hands (left or right)						
Fingers (left or right, which fingers)						
Upper back						
Mid back						
Lower back						
Hips						
Upper legs (left or right)						
Knees (left or right)						
Lower legs (left or right)						
Ankles (left or right)						
Feet (left or right)						
Toes (left or right, which toes)						

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Cause of current episode: traumatic, repetitive, post-surgical, work-related, motor vehicle, other to be explained:

_____

Date of onset current episode (or, if not specific, generally when the pain started): _____
Do these symptoms come and go: Please circle Yes or No
What makes the symptoms better: _____ worse: _____
Does this issue interfere with: Please circle: work, sleep, daily routing, recreation, other to be explained: _____

_____

Have you previously been treated for this problem, and if so, by whom: _____

Personal History

If you are female: are you currently pregnant? If yes, please provide the due date: _____

Please list medications and what condition they are for, especially if they are blood thinners:

Medication: _____ Condition: _____
Medication: _____ Condition: _____
Medication: _____ Condition: _____
Medication: _____ Condition: _____

Please list any surgeries you have had and the dates:

Surgery: _____ Date of surgery: _____
Surgery: _____ Date of surgery: _____

Please list any broken bones, sprains, strains, concussions or other injury and the date of said injury:

Injury type: _____ Date of injury: _____
Injury type: _____ Date of injury: _____
Injury type: _____ Date of injury: _____

Please list any illness you have: _____

DURING THE TREATMENT: In order to derive the greatest benefit from this work, a couple of suggestions may be helpful. First, if at any time during the treatment you notice yourself unconsciously holding your breath, simply release your breath. Exhaling releases tension, holding your breath retains tension. Second, for the same reason, if your therapist is applying pressure or stretching a muscle, also release your breath and your muscles will relax more easily. Finally, fi at any time during the treatment, anything feels uncomfortable, please tell your therapist so that he or she can adjust the technique to your particular needs.

AFTER THE TREATMENT: Everyone as a slightly different experience. Take a few moments to feel the effects of the treatment and discuss them with your therapist. You may be light headed after treatment, especially if you have never been treated before. This can happen due to the change in blood flow and onset of detoxification of the body. Be sure to drink several glasses of water (there is no replacement for water) to reduce the effects of detoxification provoked by manual therapy. If you have a headache or stomachache within two days of the treatment, you may not have had enough water.

I have read the above information and discussed it with the therapist. I understand this work does not constitute medical treatment, but rather is an adjunct to health maintenance utilizing the techniques and principles of neuro muscular therapy. I take responsibility for alerting my therapist to any physical conditions which may affect this work.

Patient's signature: _____ Dated: _____

Guardian's signature (if required): _____