PURE MUSCLE THERAPY *By Nicole #8227* *140 SE Mill St Dallas, Or*

Date_____

Full Legal Name:_____ Home Phone:(____)_____

Address:_____ Work Phone:(____)_____

City/State/Zip:_____ Cell Phone:(____)_____

Email Address:_____ Date of Birth:_____

Height:_____ Weight:_____ Age:_____ Sex:_____ Marital Status:_____

# of Children at home:_____ Ages:_____ Any Others Living at Home:_____

Date of Injury/Accident:_____ Primary Care Physician:_____

Currently under a physician's care? Yes No For Pain? Yes No Other?_____

If yes, name of physician:_____ Diagnosis given:_____

Current treatment(s):_____

Referred by physician? Yes No If no, who referred you?_____

Check all you have consulted for your symptoms:

___Physician	___MD	___Physical Therapist
___Naturopath	___DO	___Occupational Therapist
___Neurologist	___DC	___Massage Therapist
___Orthopedist	___Psychiatrist	___Acupuncturist
___Psychologist	___Counselor	___Biofeedback

___Other (specify):_____

List past surgeries and dates:_____

_____

_____

List all medication(s) you are currently taking including over-the-counter such as aspirin:

	Medication	Dosage	Frequency	Effectiveness
1.				
2.				
3.				
4.				

List all vitamins and supplements you are currently taking:_____

_____

List all allergies including food, medications, seasonal, etc:_____

_____

How much do you consume daily of: Coffee_____ Tea_____ Alcohol_____

Soft drinks_____ Chocolate_____ Cigarettes/Cigars/Tobacco_____

Are you allergic to nuts? Yes No Do you wear contact lenses? Yes No

Are you now OR do you suspect you are pregnant? Yes No

Please check any or all that apply to you: ___Right handed ___Left handed

1. Why are you here? ___Relaxation ___Injury/Accident ___Headaches
   ___Chronic condition/Other (specify):_____

2. Rate you area(s) of **current** pain by circling the number on the scale of "0" (no pain) to "10" (worst pain possible):

   Low back – 0 1 2 3 4 5 6 7 8 9 10
   Middle Back – 0 1 2 3 4 5 6 7 8 9 10
   Upper Back – 0 1 2 3 4 5 6 7 8 9 10
   Neck – 0 1 2 3 4 5 6 7 8 9 10
   Headache – 0 1 2 3 4 5 6 7 8 9 10
   Face – 0 1 2 3 4 5 6 7 8 9 10
   Chest – 0 1 2 3 4 5 6 7 8 9 10
   Abdomen – 0 1 2 3 4 5 6 7 8 9 10
   Groin – 0 1 2 3 4 5 6 7 8 9 10
   Other (specify) – 0 1 2 3 4 5 6 7 8 9 10

   Right Shoulder – 0 1 2 3 4 5 6 7 8 9 10
   Left Shoulder – 0 1 2 3 4 5 6 7 8 9 10
   Right Arm or Elbow – 0 1 2 3 4 5 6 7 8 9 10
   Left Arm or Elbow – 0 1 2 3 4 5 6 7 8 9 10
   Right Hand or Wrist – 0 1 2 3 4 5 6 7 8 9 10
   Left Hand or Wrist – 0 1 2 3 4 5 6 7 8 9 10
   Right Hip or Knee – 0 1 2 3 4 5 6 7 8 9 10
   Left Hip or Knee – 0 1 2 3 4 5 6 7 8 9 10
   Right Leg or Foot – 0 1 2 3 4 5 6 7 8 9 10
   Left Leg or Foot – 0 1 2 3 4 5 6 7 8 9 10

3. Briefly describe your symptoms and include when they began:_____
   _____

4. Did these symptoms begin as an Injury/Accident? Yes No If yes, was it:
   ___On the Job ___At Home ___Vehicle Related Seatbelt: On or Off (circle)
   ___Driver ___Passenger Front or Back Seat (circle) Other (specify):

5. What is your Current Occupation? (**not** your employer)_____
   List Previous Occupation(s)_____

6. What kind of activities **relieve or decrease** your symptoms?

___Ice	___Warm/Hot Bath	___Exercise
___Heat	___Warm/Hot Shower	___Sitting
___Activity	___Laying Down	___Resting
___Standing	___Relaxation	___Nothing
___Walking	___Medication (list):	___Other (specify):

7. What kind of activities **increase** your symptoms?

___Ice	___Warm/Hot Bath	___Exercise
___Heat	___Warm/Hot Shower	___Sitting
___Activity	___Laying Down	___Resting
___Standing	___Walking	___Nothing
___Kneeling	___Eye Movements	___Sudden Loud Noise
___Vacuuming	___Head Movements	___Reaching &/or Working Overhead
___Loud Noise	___Flashing Lights	___Driving/Riding in a Car
___Waist Bending	___Twisting Movements	___Other (specify):

8. Describe the **pattern** of your symptoms:

___Constant
___Periodic
___Transient
___Sharp
___Stabbing
___Pounding
___Fearful
___Dull/Achy
___Tingling
___Throbbing
___Tight
___Shooting
___Tender
___Hot/Burning
___Radiating
___Suffocating
___Worse on Waking
___Worse at End of the Day
___Other (specify):

9. Check any **other symptoms** you are experiencing:

___Anxiety
___Allergies
___Dizziness
___Stiffness
___Nausea
___Weight Loss
___Weight Gain
___Headaches
___Diarrhea
___Constipation
___Depression
___Shooting Pains
___Clenching Teeth
___Tiredness/Fatigue
___Sexual Dysfunction
___Shortness of Breath
___Sleep Changes: ↑ or ↓
___Pounding/Racing Heart
___Limited Movement
___Other (specify):

10. Check and date any **previous Injuries/Accidents** in which you have been involved:

___Track
___Football
___Baseball
___Basketball
___Volleyball
___Soccer
___Tennis
___Golf
___Hiking
___Falling
___Tripping
___Slipping
___Stumbling
___Jamming
___Stubbing
___Racketball
___Bicycle
___Jet Ski
___Kayaking
___Bus
___Truck
___Car
___Motorcycle
___Other Vehicle
___Bumping/Hitting Head
___Head Injury/Concussion
___Horseback Riding
___Wind Surfing
___Snow/Water Skiing
___Snow Boarding
___Roller/Ice Skating
___Gymnastics

If headaches are a main area of complaint, check all that apply in questions 11-15.

11. **How often** do you get headaches?

___Daily
___Every other day
___Once a week
___Twice a Month
___Once a Month
___Sporadically
___Rarely

12. **How long** do your headaches last?

___Hours (specify):
___One day
___Two days
___Three days
___Four days
___Longer than four days
___They never go away

13. Where in your body do you **first** feel your headache?

___Forehead
___Neck
___Jaw
___Behind your eyes
___Behind one eye
___Ear (right or left)
___Middle Back
___Upper back/shoulders
___Other (specify):

14. How would you **describe** your headache?

___A vice around your head
___Forehead pressure
___Earache
___Other (specify):
___Pressure from the inside pushing outward
___Pressure pushing on left or right side of face
___Bright lights followed by extreme pain

15. What time of day do you **first** notice your headache?

___Upon first waking
___After getting out of bed
___Mid morning
___Noon
___Other (specify):
___Early afternoon
___Late afternoon
___Early evening
___Late evening

16. **Check** all conditions/symptoms for which you **have been** or are **currently** being treated:

Skin Conditions:
- ___Eczema
- ___Cancer
- ___Herpes
- ___Psoriasis
- ___Athlete's foot
- ___Ring worm
- ___Acne
- ___Burns
- ___Other (specify):

Respiratory Conditions:
- ___Asthma
- ___Bronchitis
- ___Collapsed Lung
- ___Lung disease
- ___Chest Pain
- ___Pulmonary embolus
- ___Tuberculosis
- ___Emphysema
- ___Other (specify):

Nervous System Conditions:
- ___Multiple Sclerosis
- ___Sciatica
- ___Neuroma
- ___Neuritis/Neuropathy
- ___Neuralgia
- ___Pinched nerve
- ___Numbness/Loss of sensation
- ___Bulging Disk
- ___Ruptured Disk
- ___Other (specify):

Circulatory Conditions:
- ___Phlebitis
- ___Blood Clots
- ___Varicosities
- ___High/Low Blood pressure
- ___Heart disease
- ___Pacemaker
- ___Angina
- ___Stroke
- ___High cholesterol
- ___Irregular heart beat
- ___Bruise easily
- ___Other (specify):

Digestive/Urinary Conditions:
- ___Ulcer
- ___Colitis/Crohn disease
- ___Irritable Bowel
- ___Gall Bladder/stones
- ___Bladder infection
- ___Kidney infection/stones
- ___Nephropathy
- ___Chronic Renal Failure
- ___Liver Disorder
- ___Chronic Constipation
- ___Chronic Diarrhea
- ___Acid reflux
- ___Gas/Bloating
- ___Other (specify):

Muscle/Tendon Conditions:
- ___Sprain
- ___Strain
- ___Tendonitis
- ___Bursitis
- ___Fibromyalgia
- ___Chronic Stiffness
- ___Leg/Foot Cramps
- ___Muscle weakness
- ___Limited movement
- ___Other (specify):

Osteopathic Conditions:
- ___Broken bones
- ___Osteoporosis
- ___Osteoarthritis
- ___Degenerative hip/shoulder/knee
- ___*Joint replacement (specify):*
- ___Other (specify):

Lymphatic Conditions:
- ___Chronic colds
- ___Chronic flu
- ___Swollen Lymph Nodes
- ___Lymphedema
- ___*Other (specify):*

Other Conditions/Symptoms:
- ___Post Polio
- ___Cancer
- ___Ulcers
- ___Anemia
- ___Stroke
- ___Asthma
- ___Bursitis
- ___Diabetes (Type 1)
- ___Diabetes (Type 2)
- ___Menstrual Cramping
- ___Ovarian Cancer
- ___Kidney infections
- ___Fibromyalgia
- ___Vertigo
- ___Ringing in ears/Tinnitus
- ___Charcot-Marie-Tooth
- ___HIV+
- ___AIDS
- ___PMS
- ___TMJ
- ___Gout
- ___Alcoholism
- ___Emphysema
- ___Weight Loss
- ___Lupus
- ___Endometriosis
- ___Cervical Cancer
- ___Kidney disease
- ___Fibrocystic Breasts
- ___Dizziness
- ___Ménière syndrome
- ___Other (specify):
- ___Rheumatoid Arthritis
- ___Tuberculosis
- ___Heart disease
- ___High or Low Thyroid
- ___Chronic sinus infections
- ___Dizziness or Fainting spells
- ___Nipple tenderness/discharge
- ___Weight gain
- ___Raynaud Syndrome
- ___Breast Cancer
- ___Perimenopausal symptoms
- ___Post menopausal symptoms
- ___Kidney Stones
- ___Ovarian Cysts
- ___Endometriosis