_____ _____

Patient or Authorized Representative Date

_____ _____

Relationship to patient (if other than patient) (Patient name printed)

Medical History: Circle each of the topics that relate to your medical history

□ Allergies
□ Allergic to latex
□ Amputation
□ Anemia
□ Angina
□ Ataxia
□ Bell's Palsy
□ Blood clot/
□ Bowel/bladder problems
□ Bronchitis
□ Cancel
□ Carpal Tunnel Syndrome
□ Kidney Disease
□ Lipedema
□ Low blood pressure
□ Low blood sugar
□ Lymphedema
□ Lupus
□ Lyme Disease
□ Mastectomy
□ Cellulitis
□ Cerebral palsy
□ Complex regional pain syndrome
□ Concussion
□ COPD
□ Coronary heart disease
□ Depression
□ Diabetes, Type 1
□ Diabetes, Type 2
□ Dizziness or faintness
□ Drink alcohol
□ Emphysema
□ Oxygen dependency
□ Pacemaker
□ Parkinson's disease
□ Pelvic floor issues
□ Pneumonia
□ Pregnancy, currently
□ Rheumatoid arthritis
□ Sciatica
□ Epilepsy/Seizures
□ Epstein-Barr
□ Gout
□ Guillain-Barre Syndrome
□ Headaches, severe
□ Hearing Difficulties
□ Heart attack
□ Heart disease
□ Hernia
□ High blood pressure
□ Incontinence
□ Infectious disease
□ Thyroid
□ Tobacco use
□ Torticollis
□ Varicose Veins
□ Vertigo/Balance
□ Vision difficulties
□ Weakness
□ Weight loss

Medical History: Circle each of the topics that relate to your medical history

□ Multiple sclerosis
□ Neurological issues
□ Osteoarthritis
□ Osteoporosis
□ Abdomen
□ Ankle, left
□ Ankle, right
□ Arm, left
□ Arm, right
□ Back, lower
□ Back, middle
□ Back, upper
□ Buttock, left
□ Buttock, right
□ Chest, left
□ Chest, right
□ Constipation
□ CRPS, left
□ CRPS, right
□ Elbow, left
□ Sleep apnea
□ Sleeping problems
□ Spinal stenosis
□ Stroke/TIA
□ Elbow, right
□ Feet, toes, left
□ Feet, toes, right
□ Groin
□ Hands, fingers, left
□ Hands, fingers, right
□ Head, left
□ Head, right
□ Hip, left
□ Hip, right
□ Jaw, left
□ Jaw, right
□ Knees, left
□ Knees, right
□ Leg, left
□ Leg, right
□ Women's health issues
□ Other surgery
□ Wrist, left
□ Wrist, right
□ Neck, left
□ Neck, right
□ Pelvis
□ Rectal
□ Shoulder, left
□ Shoulder, right
□ Vagina

Please tell us what prompted today's visit

OTHER FACTORS:

How often do you exercise?

□ Never

□ Once per week

□ Twice per week

□ 3 times per week

□ 4 or more times per week

Does your daily routine, or work, aggravate your pain injury?

□ No

□ I am unable to participle in my normal routines or work

□ My routine/work usually impacts my pain/injury 1 day a week

□ My routine/work usually impacts my pain/injury 2 days a week

□ My routine/work usually impacts my pain/injury 3 day a week

□ My routine/work aggravate by injury every day, but I try to cope

Circle the type of pain you have

□ Aching

□ Burning

□ Constant

□ Cramping

□ Deep

□ Dull

□ Heavy

□ Numb

□ Pins/Needles

□ Stabbing

□ Throbbing

□ Variable

□ Weak

How is your pain level, when it is at its worst?

0 1 2 3 4 5 6 7 8 9 10

(10 Worst pain you have had)

How is your pain level, when you feel best?

0 1 2 3 4 5 6 7 8 9 1

Circle any of these activities that make your pain/injury worse

□ Reaching back
□ Lying flat
□ Getting in and out of bed
□ Dressing/Grooming
□ Cooking
□ Carrying items
□ Climbing stairs
□ Twisting
□ Lifting light weights
□ Lifting heavy weights
□ Pulling
□ Raising arm overhead
□ Looking up/down
□ Walking

Do you any these relieve your pain?

□ Ice
□ Heat
□ Stretching
□ Exercise
□ Pain Medication
□ Lying flat
□ Avoiding activity
□ Nothing

Please list any medications that you are currently taking with dosage

_____
_____
_____
_____
_____

Please enter height and weight?

Enter feet _____ Enter inches_____ Weight_____