Name_____ Today's Date_____

Address_____ City,State,Zip_____

Home Phone_____ Cell_____ Date of Birth_____

Email Address_____ How were you referred here?_____

Employer_____ Occupation_____

Emergency Contact_____ Emergency Phone_____

Primary Healthcare Provider / Facility _____

Health History:

Surgeries_____

Injuries_____

Major Illnesses_____

Check any current and/or previous conditions:

General

Current	Past	
☐	☐	headaches
☐	☐	pain
☐	☐	sleep disturbances
☐	☐	fatigue
☐	☐	infections
☐	☐	fever
☐	☐	sinus
☐	☐	other_____

Muscles and Joints

☐	☐	rheumatoid arthritis
☐	☐	osteoarthritis
☐	☐	scoliosis
☐	☐	broken bones
☐	☐	spinal problems
☐	☐	disk problems
☐	☐	lupus
☐	☐	TMJ / jaw pain
☐	☐	spasms/cramps
☐	☐	sprains/strains
☐	☐	tendonitis/bursitis
☐	☐	stiff or painful joints
☐	☐	weak or sore muscles
☐	☐	neck/shoulder/arm pain
☐	☐	low back/hip/leg pain
☐	☐	other_____

Nervous System

☐	☐	head injuries/concussions
☐	☐	dizziness/ringing in ears
☐	☐	loss of memory/confusion
☐	☐	numbness/tingling
☐	☐	sciatica/shooting pain
☐	☐	chronic pain
☐	☐	depression
☐	☐	other_____

Respiratory / Cardiovascular

☐	☐	heart disease
☐	☐	blood clots
☐	☐	stroke
☐	☐	lymphedema
☐	☐	high/low blood pressure
☐	☐	irregular heat beat
☐	☐	poor circulation
☐	☐	swollen ankles
☐	☐	varicose veins
☐	☐	chest pain
☐	☐	shortness of breath
☐	☐	asthma

Skin Conditions

☐	☐	rashes
☐	☐	athlete's foot/warts
☐	☐	other_____

Allergies

☐	☐	scents/oils/lotions
☐	☐	detergents
☐	☐	other_____

Digestive/Elimination System

☐	☐	bowel problems
☐	☐	gas/bloating
☐	☐	bladder/kidney/prostrate
☐	☐	abdominal pain
☐	☐	other_____

Endocrine System

☐	☐	thyroid
☐	☐	diabetes

Reproductive System

☐	☐	pregnancy
☐	☐	painful/emotional menses
☐	☐	fibrotic cysts

Cancer/Tumors

☐	☐	benign
☐	☐	malignant

Habits

☐	☐	tobacco
☐	☐	alcohol
☐	☐	drugs
☐	☐	coffee/soda

Contract for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

Consent for Care

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature_____ Date_____