Patient Information

Name: ______________________________ Date: ______________________

Age: __________ Height: __________ Weight: __________

Occupation: ____________________ Do You Exercise? ☐ Yes ☐ No If yes, how often: __________

Are you on work restriction from your doctor? ☐ Yes ☐ No Are you latex sensitive? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Do you have a pacemaker? ☐ Yes ☐ No

FOR WOMEN: Are you pregnant or think you might be pregnant? ☐ Yes ☐ No

ALLERGIES: List any medication(s) you are allergic to: ______________________________

Have you RECENTLY noted any of the following (check all that apply)?

☐ Fatigue
☐ Fever/chills/sweats
☐ Nausea / vomiting
☐ Unexplained weight loss/gain
☐ Difficulty maintianing balance while walking
☐ Falls
☐ Numbness or tingling
☐ Muscle weakness
☐ Dizziness / lightheadedness
☐ Heartburn / indigestion
☐ Difficulty Swallowing
☐ Changes in bowel or bladder function
☐ Constipation
☐ Diarrhea
☐ Shortness of breath
☐ Depression
☐ Cough
☐ Headaches

Please list any medications you are currently taking including pills, injections and/or skin patches. (You may also provide us with a copy of your medication)

1. ____________________ 2. ____________________ 3. ____________________
4. ____________________ 5. ____________________ 6. ____________________

Have you had recent surgery? ☐ Yes ☐ No Type of Surgery ______________ Date: ____________

Have you had home health care recently? ☐ Yes ☐ No If yes, date of discharge: ______________

What date approximately did your present symptoms start? ____________________

What do you think caused your symptoms? ______________________________

I should not do physical activites that might make my pain worse ☐ Disagree ☐ Unsure ☐ Agree

Treatment received so far: (chiropractic, physical therapy, injections, surgery, etc.) ____________________

Please list special tests performed for this problem: (x-ray, MRI, labs, etc.) ____________________

What, if any, restrictions have been imposed by your physician? ____________________

Have you ever had this problem before? ☐ Yes ☐ No When __________ Treatment received __________

How long did it take for you to feel better? ______________________________

Do your symptoms: ☐ Come and go ☐ Are constant
☐ Are constant, but change with activity

How are you currently able to sleep at night due to your symptoms?
☐ No problem sleeping ☐ Difficulty falling asleep
Awakened by pain Sleep only with medication

When are your symptoms worst?
☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After excercise

When are your symptoms best?
☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After excercise

Body Chart:
Please mark the areas where you feel symptoms on the chart to the right. Indicate the type of pain such as: Sharp, Shooting, Dull, Throbbing, Numbness / Tingling etc.