

Name: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> changes in appetite                          | <input type="checkbox"/> dizziness/lightheadedness | <input type="checkbox"/> pain at night       |
| <input type="checkbox"/> changes in bowel or bladder function         | <input type="checkbox"/> fever/chills/sweats       | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> headaches                 | <input type="checkbox"/> weakness/fatigue    |
| <input type="checkbox"/> difficulty swallowing                        | <input type="checkbox"/> nausea/vomiting           | <input type="checkbox"/> weight loss/gain    |

**Have you EVER been diagnosed with any of the following conditions (check all that apply)?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> anemia                                 | <input type="checkbox"/> heart disease         | <input type="checkbox"/> Parkinson's disease  |
| <input type="checkbox"/> asthma                                 | <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> cancer (type) _____                    | <input type="checkbox"/> kidney/liver problems | <input type="checkbox"/> stomach ulcers       |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> lung problems         | <input type="checkbox"/> stroke               |
| <input type="checkbox"/> depression                             | <input type="checkbox"/> multiple sclerosis    | <input type="checkbox"/> thyroid problems     |
| <input type="checkbox"/> diabetes                               | <input type="checkbox"/> osteoporosis          | <input type="checkbox"/> other _____          |
| <input type="checkbox"/> epilepsy                               | <input type="checkbox"/> pacemaker inserted    | <input type="checkbox"/> other _____          |

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, but not today NO

Do you smoke? YES NO \_\_\_\_\_ pack/day

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Please list current medications: \_\_\_\_\_  See Attached

Are you currently taking blood thinning or anticoagulant medications for any medical conditions? YES NO

ALLERGIES: \_\_\_\_\_

Are you latex sensitive? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

**For the injury you are seeing us for today:**

**Pain at LOWEST: Rate your lowest pain level IN THE PAST 3 DAYS.**

0 1 2 3 4 5 6 7 8 9 10  
No pain Worst pain  
Imaginable

**Pain Currently: Rate your level of pain now.**

0 1 2 3 4 5 6 7 8 9 10  
No pain Worst pain  
Imaginable

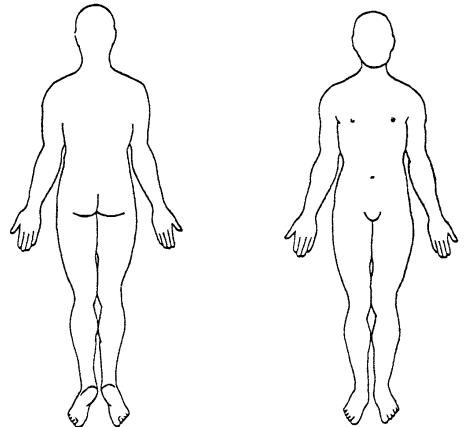
**Pain at WORST: Rate your highest pain level IN THE PAST 3 DAYS.**

0 1 2 3 4 5 6 7 8 9 10  
No pain Worst pain  
Imaginable

**Body Chart:**

Please mark the location of your pain and type of pain on the chart:

Key:  
X sharp stabbing pain  
O Dull achy pain  
... Numb/Tingling  
/// Throbbing  
== Burning



What is your goal for therapy at this time? \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_