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

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| **INJURY/AREA OF CONCERN** |
| Area of injury/concern:  | Date of injury (if known): |
| Severity of Symptoms: Best (0-10): Current (0-10): Worst (0-10): |
| Goals for therapy: |
| Have you seen a therapist, chiropractor, or acupuncturist for this condition? **Yes No** If yes, which and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Have you received outpatient or home health therapy in the last 60 days? **Yes No**Are you currently seeing any specialists? **Yes No** |
| **MEDICATIONS AND ALLERGIES** |
| Please list any known allergies: |
| Please list any prescriptions, over-the-counter medications, and nutritional supplements you take (or attach a list): |
| **MEDICAL AND SURGICAL HISTORY** |
| Have you been diagnosed with or treated for any of the following? (check all that apply) |
| * Alzheimer’s/Dementia
* Problems of heart or blood vessels (cardiovascular)
* Pacemaker
* Cauda equina syndrome
* Stroke (cerebrovascular accident)
* Infections or infectious disease (TB/HIV/Hepatitis)

 Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* Type 1 Diabetes
* Type 2 Diabetes
* Fibromyalgia
* Fracture or suspected fracture

 Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* High blood pressure
* High cholesterol
* Huntington’s Disease
* Cancer, Past
* Cancer, Current
* Immunosuppression
* Lupus
* Muscular dystrophy
 | * Obesity
* Osteoporosis
* Osteopenia
* Osteoarthritis
* Parkinson’s disease
* Rheumatoid arthritis
* Head injury or trauma
* Asthma
* Depression, anxiety, or other psychological disorders
* Hereditary disorders or diseases
* Endocrine disorders: thyroid, prostate etc.
* Digestive problems (throat, stomach, bowels)
* Urinary problems
* Kidney problems
* Liver (hepatic) problems (ex: cirrhosis)
* Seizures
* Peripheral neuropathy
* Currently pregnant
* History of COVID
 |

Continued on back. **→**

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| **MEDICAL AND SURGICAL HISTORY Cont.**  |
| Please list any other conditions or ailments not previously listed: |
| Have you recently had any of the following symptoms? (check all that apply) |
| * Trouble breathing
* Chest pain/heart palpitations
* Numbness/tingling
* Feeling fatigued, weak, or ill
* Nausea or vomiting
* Headaches or visual changes
* Excessive bleeding/bruising
* Stiffness in many joints
 | * Difficulty balancing
* Confusion or forgetfulness
* Difficulty swallowing
* Leg cramps, redness, or tenderness
* Fainting/blackouts or dizziness/ lightheadedness
* Sadness/fear/anxiety
* Urinary or bowel changes
 | * Constant, relentless pain
* Pain at night
* Night sweats/fever/chills
* Recent changes in weight or appetite
* Unusual lumps/growths
* Other: please specify
 |
| Please list any prior surgeries you’ve had with approximate dates: |

**Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_