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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_