Patient Form

Patient Information:

Full Name: _____ Age: _____ ☐ Female ☐ Male

Date of birth: _____ Phone: _____

Address: _____ City: _____ ZIP Code: _____

Email Address: _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Text

Emergency Contact Name: _____

Relationship: _____ Phone: _____

What body area(s) are you seeking evaluation for? (check all that apply)

☐ Neck	☐ Shoulder (L / R)	☐ Hip (L / R)	☐ Headache
☐ Mid Back	☐ Elbow (L / R)	☐ Knee (L / R)	☐ Chest / Ribs
☐ Low Back	☐ Wrist / Hand (L / R)	☐ Ankle / Foot (L / R)	☐ Abdomen

☐ Other: _____

When did your symptoms begin?

☐ Today	☐ Past week	☐ Past month	☐ 1-3 months
☐ 3-6 months	☐ > 1 year	☐ Unsure	☐ Other: _____

How would you rate the intensity of your symptoms?

☐ minimal	☐ mild	☐ mild to moderate
☐ moderate	☐ moderate to severe	☐ severe

What is the frequency of your symptoms?

☐ Rare ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

How are your symptoms progressing?

☐ Changes Daily ☐ Improving ☐ Not improving ☐ Worsening

Describe the symptoms you're experiencing: (please select all that apply)

☐ Achy	☐ Burning	☐ Numbness/Tingling	☐ Muscle Spasm
☐ Sharp	☐ Throbbing	☐ Stiffness	☐ Trouble Sleeping
☐ Dull	☐ Radiating	☐ Weakness	☐ Other: _____

What self-care treatment have you tried to help symptoms? (please select all that apply)

□ Rest □ Stretching □ OTC Medication
□ Ice □ Exercise □ TENS □ Other: _____
□ Heat □ Massage □ None

What physical limitations do you have?

□ no limitations □ mild to moderate limitations □ severe limitations
□ mild limitations □ moderate limitations □ completely limited

What is your current work status? (select all that apply)

□ Working without restrictions □ Missed work due to symptoms □ Not employed
□ Working with restrictions □ Currently off work

Cardiovascular (CHECK ONLY IF YES)

□ Chest Pain □ Shortness of breath □ Dizziness □ Irregular Heartbeat

Respiratory (CHECK ONLY IF YES)

□ Chest tightness □ Chronic cough

Neurologic (CHECK ONLY IF YES)

□ Balance Problems □ Weakness □ Numbness/tingling
□ Memory Issues □ Speech Difficulty

Musculoskeletal (CHECK ONLY IF YES)

□ Back Pain □ Neck Pain □ Joint pain/stiffness
□ Muscle aches/spasms □ Leg Pain □ Sciatica

General (CHECK ONLY IF YES)

□ Fatigue □ Fever □ Headache □ Sleep disturbance

ENT / Eyes (CHECK ONLY IF YES)

□ Vision changes □ Ringing in ears □ Sinus problems
□ Sore throat □ Speech Difficulty

Psychiatric (CHECK ONLY IF YES)

□ Anxiety □ Depressed mood

Genitourinary (CHECK ONLY IF YES)

□ Abdominal pain/swelling □ Frequent urination
□ Painful urination □ Blood in urine

Past Medical History (check all that apply)

□ High blood pressure
□ Diabetes (Type □1 □2)
□ Stroke
□ Cancer (type): _____
□ Osteoporosis
□ Rheumatoid arthritis
□ Scoliosis
□ Thyroid disease
□ Vertigo
□ Bleeding disorder
□ HIV/AIDS
□ Hepatitis
□ Pacemaker / Defibrillator
□ Other: _____

Problem Areas

***Denotes required information**

*Describe your problem:

_____
_____
_____

*On a scale of 0-10, rate your intensity: **Lowest - 1 2 3 4 5 6 7 8 9 10 - Highest**

*How did your problem begin:

_____
_____
_____

*When did your problem begin? (***exact date if possible***)

_____

How often do you experience symptoms: _____

How would you describe your symptoms?

□ Dull
□ Aching
□ Deep
□ Sore
□ Stiff
□ Tight
□ Sharp
□ Stabbing
□ Shooting
□ Cramping
□ Spasm
□ Throbbing
□ Burning
□ Numbness
□ Tingling
□ Weakness

Does it radiate, shoot, or travel to other areas of your body? □ Yes □ No

If so, to what areas does the pain radiate, shoot, or travel?

_____

What makes it **better**? (Times of day, movements, activities, etc):

_____

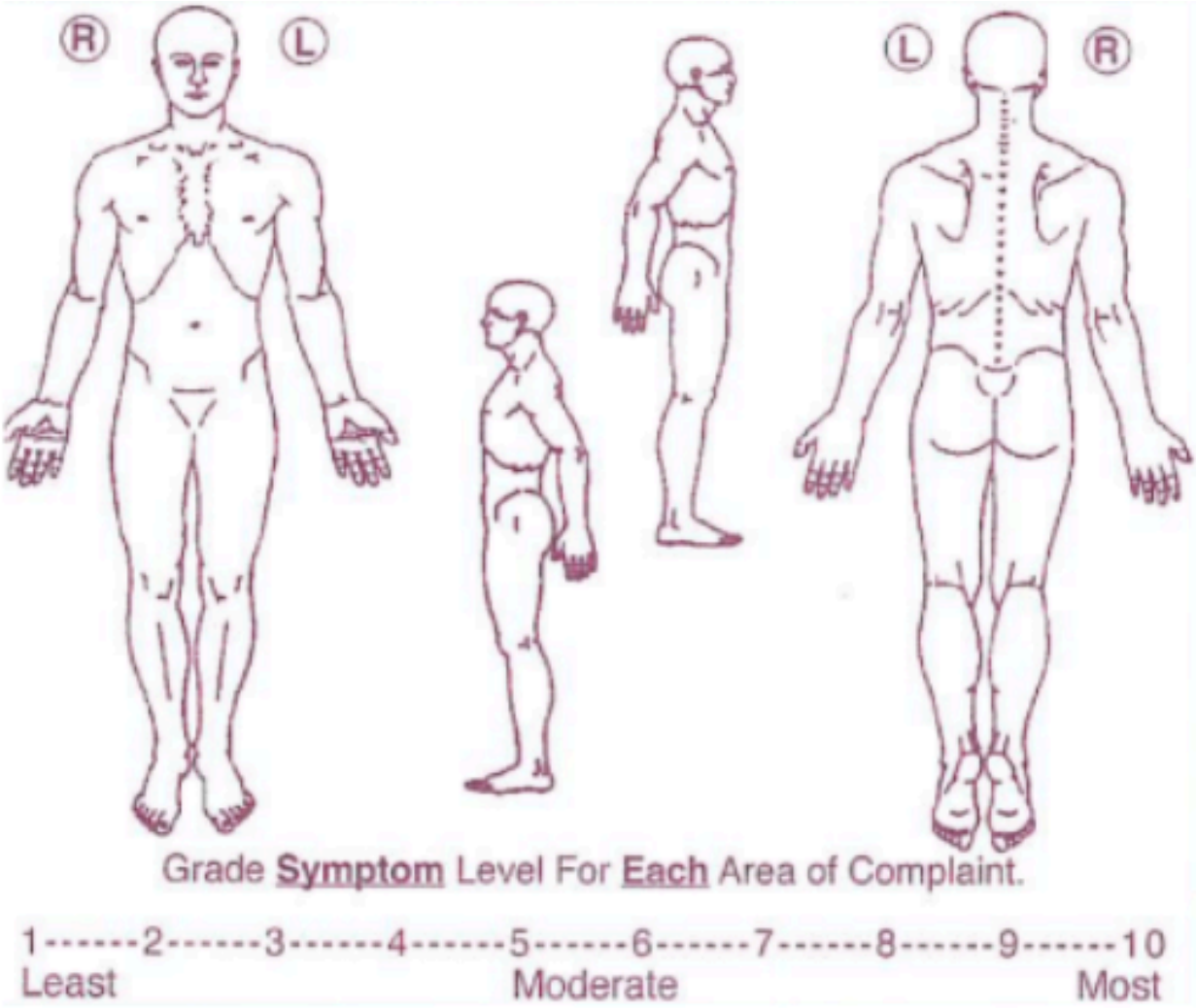
What makes it **worse**? (Times of day, movements, activities, etc):

_____

What have you done to relieve the symtoms?

□ Ice
□ Heat
□ Rest
□ Sitting
□ Lying down
□ Stretching
□ Exercise
□ Prescription Medication
□ Over the counter medication
□ Massage
□ Acupuncture
□ Chiropractic Adjustment
□ Physical Theraphy
□ Injections
□ Surgery
□ Other: _____

Location of Symptoms



Patient/Legal Guardian Signature: _____

Print Name: _____

Date: _____