Welcome to our practice!

Last Name: ____________________________ **First Name:** _______________________ **M.I.** ______

Address: ____

Home Phone: _____________________ **Mobile:** ___________________ **Work:** ____________________

Email: ____

DOB: _______________ **Age:** ____ **Height/Weight:** ___________ **Marital Status:** **M S W D**

Emergency Contact: ___________________________ **Phone:** ___________ **Relation:** ____________

Primary Doctor: _______________________________ **Phone:** _____________ **Location:** __________

Specialist: ____________________________________ **Phone:** ______________ **Location:** _________

How did you hear about our practice? ____

Are you at risk for falls? **Y N**

Do you have discomfort, shortness of breath, or pain with exercise? **Y N**

If "yes", please describe: ____

Do you smoke: **Y N** **If "yes", how much?** ________________

If you previously smoked, when did you quit? _____________________

What is your primary issue/problem that brings you in today? ________________________________

Secondary concern/problem? ____

Existing or relevant previous conditions? ____

Treatment sought for this condition					
Massage:		**Bodywork:**		**Physical Therapy:**	
Myofascial Release:		**Chiropractic:**		**Surgery:**	

Please rate your pain in the last 24 - 72 hours on a scale of 0-10 where “0” is no pain and “10” is the worst possible pain.					
At worst:		At best:		At present:	

Patient Goals

Please list the activities that you would like to be able to do as a result of therapy.

Task / Activity	Duration / How Often	Rate Difficulty 0-10 0 = unable to perform, 10 = perform at same level prior to injury

Other Goals:

List past medical history and dates of occurrence. General dates are okay. Include surgeries, accidents and other traumas going back to birth

List ALL medications which you are currently taking. Include supplements, herbal and homeopathic remedies		
Medication	Dose / Amount per day	For treatment of