Welcome to our practice!

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

Address: ____**Zip:**_______________

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? ____________________

List existing medical or previous conditions (e.g. high blood pressure/cholesterol):

____

____

____

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

Secondary concern/problem? ____

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 surgeries, accidents and other traumas going back to birth. General dates are okay

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