



**Patient Information**

Name: \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: Home \_\_\_\_\_  
Work \_\_\_\_\_ Cell \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Insurance ID#: \_\_\_\_\_  
Emergency Contact \_\_\_\_\_  
Phone: Home \_\_\_\_\_  
Work \_\_\_\_\_ Cell \_\_\_\_\_

**Current Health Information**

List health concern(s). Check all that apply.

- Primary \_\_\_\_\_  
Severity?  Mild  Moderate  Disabling  
Duration?  Constant  Intermittent  
Do symptoms change with activity?  
 Symptoms increase  Symptoms decrease  
Are symptoms?  
 Getting worse  Getting better  No change  
Treatment received \_\_\_\_\_
- Secondary \_\_\_\_\_  
Severity?  Mild  Moderate  Disabling  
Duration?  Constant  Intermittent  
Do symptoms change with activity?  
 Symptoms increase  Symptoms decrease  
Are symptoms?  
 Getting worse  Getting better  No change  
Treatment received \_\_\_\_\_
- Additional \_\_\_\_\_  
Severity?  Mild  Moderate  Disabling  
Duration?  Constant  Intermittent  
Do symptoms change with activity?  
 Symptoms increase  Symptoms decrease  
Are symptoms?  
 Getting worse  Getting better  No change  
Treatment received \_\_\_\_\_
- List all conditions currently monitored by a Health Care Provider \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Primary Health Care Provider**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
I give my manual therapist permission to consult with my referring health care provider regarding my health and treatment.  
Comments \_\_\_\_\_  
Initials \_\_\_\_\_ Date \_\_\_\_\_

**Health History**

List and Explain. Include dates and treatment.

Surgeries \_\_\_\_\_  
\_\_\_\_\_  
Accidents \_\_\_\_\_  
\_\_\_\_\_  
Major Illnesses \_\_\_\_\_  
\_\_\_\_\_  
List the medications you took today (include pain relievers and herbal remedies) \_\_\_\_\_  
\_\_\_\_\_  
List all other medications taken in the last three months \_\_\_\_\_  
\_\_\_\_\_  
Have you ever received Manual Therapy before?  
 Yes  No Frequency? \_\_\_\_\_

**List Daily Activities**

Work \_\_\_\_\_  
\_\_\_\_\_  
Home/Family \_\_\_\_\_  
\_\_\_\_\_  
Social/Recreational \_\_\_\_\_  
\_\_\_\_\_  
Circle the activities affected by your condition, or check here  to indicate all of the above.  
Check other activities affected:  
 Sleeping  Washing  Dressing  Fitness  
How do you reduce stress? \_\_\_\_\_  
\_\_\_\_\_  
Pain? \_\_\_\_\_  
\_\_\_\_\_  
What are your goals for receiving Manual Therapy? \_\_\_\_\_  
\_\_\_\_\_

Please check all current and past conditions. Please explain.

**General**

- |                          |                          |                    |
|--------------------------|--------------------------|--------------------|
| Current                  | Past                     |                    |
| <input type="checkbox"/> | <input type="checkbox"/> | Headaches          |
| <input type="checkbox"/> | <input type="checkbox"/> | Pain               |
| <input type="checkbox"/> | <input type="checkbox"/> | Sleep disturbances |
| <input type="checkbox"/> | <input type="checkbox"/> | Fatigue            |
| <input type="checkbox"/> | <input type="checkbox"/> | Infectious         |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever              |
| <input type="checkbox"/> | <input type="checkbox"/> | Sinus              |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____        |

**Skin Conditions**

- |                          |                          |                       |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rashes                |
| <input type="checkbox"/> | <input type="checkbox"/> | Athlete's foot, Warts |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____           |

**Allergies**

- |                          |                          |                       |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Scents, Oils, Lotions |
| <input type="checkbox"/> | <input type="checkbox"/> | Detergents            |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____           |

**Nervous System**

- |                          |                          |                                |
|--------------------------|--------------------------|--------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Head injuries, Concussions     |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness, Ringing in the ears |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of memory, Confusion      |
| <input type="checkbox"/> | <input type="checkbox"/> | Numbness, Tingling             |
| <input type="checkbox"/> | <input type="checkbox"/> | Sciatica, Shooting pain        |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic pain                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____                    |

**Digestive/Elimination System**

- |                          |                          |                               |
|--------------------------|--------------------------|-------------------------------|
| Current                  | Past                     |                               |
| <input type="checkbox"/> | <input type="checkbox"/> | Bowel dysfunction             |
| <input type="checkbox"/> | <input type="checkbox"/> | Gas, bloating                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Bladder or Kidney dysfunction |
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain                |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____                   |

**Muscles and Joints**

- |                          |                          |                          |
|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid arthritis     |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoarthritis           |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis             |
| <input type="checkbox"/> | <input type="checkbox"/> | Scoliosis                |
| <input type="checkbox"/> | <input type="checkbox"/> | Broken bones             |
| <input type="checkbox"/> | <input type="checkbox"/> | Spinal problems          |
| <input type="checkbox"/> | <input type="checkbox"/> | Disk problems            |
| <input type="checkbox"/> | <input type="checkbox"/> | Lupus                    |
| <input type="checkbox"/> | <input type="checkbox"/> | TMJ, Jaw pain            |
| <input type="checkbox"/> | <input type="checkbox"/> | Spasms, Cramps           |
| <input type="checkbox"/> | <input type="checkbox"/> | Sprains, Strains         |
| <input type="checkbox"/> | <input type="checkbox"/> | Tendonitis, Bursitis     |
| <input type="checkbox"/> | <input type="checkbox"/> | Stiff or painful joints  |
| <input type="checkbox"/> | <input type="checkbox"/> | Weak or sore muscles     |
| <input type="checkbox"/> | <input type="checkbox"/> | Neck, shoulder, arm pain |
| <input type="checkbox"/> | <input type="checkbox"/> | Back, hip, leg pain      |
| <input type="checkbox"/> | <input type="checkbox"/> | Other _____              |

**Endocrine System**

- |                          |                          |                     |
|--------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | thyroid dysfunction |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes            |

**Respiratory, Cardiovascular**

- |                          |                          |                                 |
|--------------------------|--------------------------|---------------------------------|
| Current                  | Past                     |                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Lymphedema                      |
| <input type="checkbox"/> | <input type="checkbox"/> | High or low blood pressure      |
| <input type="checkbox"/> | <input type="checkbox"/> | Irregular heart beat            |
| <input type="checkbox"/> | <input type="checkbox"/> | Poor circulation                |
| <input type="checkbox"/> | <input type="checkbox"/> | Swollen ankles                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicose veins                  |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain, Shortness of breath |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Other?                          |

**Reproductive System**

- |                          |                          |                             |
|--------------------------|--------------------------|-----------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Painful or emotional menses |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibrotic cysts              |

**Cancer/Tumors**

- |                          |                          |           |
|--------------------------|--------------------------|-----------|
| <input type="checkbox"/> | <input type="checkbox"/> | Benign    |
| <input type="checkbox"/> | <input type="checkbox"/> | Malignant |

**Habits**

- |                          |                          |              |
|--------------------------|--------------------------|--------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Alcohol      |
| <input type="checkbox"/> | <input type="checkbox"/> | Drugs        |
| <input type="checkbox"/> | <input type="checkbox"/> | Coffee, Soda |

**Contract for Care**

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

**Consent for Care**

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_