

Provider Name _____

HEALTH INFORMATION

Patient Name _____ Date _____

Date of Injury _____ Insurance ID# _____

A. Patient Information

Address _____

City _____ State _____ Zip _____

Phone: Home _____

Work _____ Cell/Pgr _____

Date of Birth _____

Employer _____

Occupation _____

Emergency Contact _____

Phone: Home _____

Work _____ Cell/Pgr _____

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 _____

B. Current Health Information

List Health/Concerns Check all that apply

Primary _____

mild moderate disabling

constant intermittent

symptoms ↑ w/activity ↓ w/activity

getting worse getting better no change
treatment received _____

Secondary _____

mild moderate disabling

constant intermittent

symptoms ↑ w/activity ↓ w/activity

getting worse getting better no change
treatment received _____

Additional _____

mild moderate disabling

constant intermittent

symptoms ↑ w/activity ↓ w/activity

getting worse getting better no change
treatment received _____

Have you ever received Manual Therapy before? Y N Frequency? _____

List all conditions currently monitored by a Health Care Provider _____

List the medications you took today (include pain relievers and herbal remedies)

List all other medications taken in the last 3 months _____

List Daily Activities

Work _____

Home/Family _____

Social/Recreational _____

Circle the activities affected by your condition,

all of the above

Check other activities affected: sleep

washing dressing fitness

How do you reduce stress? _____

Pain? _____

What are your goals for receiving Manual Therapy? _____

C. Health History

List and Explain. Include dates and treatment received.

Surgeries _____

Accidents _____

Major Illnesses _____

General

current	past	comments
<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

current	past	comments
<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

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	scents, oils, lotions _____
<input type="checkbox"/>	<input type="checkbox"/>	detergents _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Muscles and Joints

current	past	comments
<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"/>	low back, hip, leg pain _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Nervous System

current	past	comments
<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 _____

Respiratory, Cardiovascular

current	past	comments
<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"/>	lymphadema _____
<input type="checkbox"/>	<input type="checkbox"/>	high, 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 _____

Digestive/ Elimination System

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	bowel dysfunction _____
<input type="checkbox"/>	<input type="checkbox"/>	gas, bloating _____
<input type="checkbox"/>	<input type="checkbox"/>	bladder/kidney dysfunction _____
<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

Endocrine System

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	thyroid dysfunction _____
<input type="checkbox"/>	<input type="checkbox"/>	diabetes _____

Reproductive System

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	pregnancy _____
<input type="checkbox"/>	<input type="checkbox"/>	painful, emotional menses _____
<input type="checkbox"/>	<input type="checkbox"/>	fibrotic cysts _____

Cancer/Tumors

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	benign _____
<input type="checkbox"/>	<input type="checkbox"/>	malignant _____

Habits

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	tobacco _____
<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 _____
(if patient is a minor)