HEALTH HISTORY & NEW PATIENT INTAKE FORM

Bold fields are required.

Date		***Emergency contact***	
Name (First, Last, MI)		***Phone #***	
Address		PCP or referring Physician	
City/State/Zip		*Address*	
Age / Date of Birth		*Suite Number*	
Sex		*City/State/Zip*	
Home phone		*Phone number*	
Work phone		*Fax Number*	
Mobile phone		I give my manual therapist permission to consult with my referring health care provider regarding my health and	Signature
e-Mail			

Current Health Information

Please list concerns and check all that apply

What is your Primary Complaint? _____

☐ mild ☐ moderate ☐ severe

☐ constant ☐ intermittent

☐ symtoms ⇧ w/activity ☐ symptoms ⇩ w/activity

☐ getting worse ☐ getting better ☐ no change

Treatment received _____

What is your Secondary Concern? _____

☐ mild ☐ moderate ☐ severe

☐ constant ☐ intermittent

☐ symtoms ⇧ w/activity ☐ symptoms ⇩ w/activity

☐ getting worse ☐ getting better ☐ no change

Treatment received _____

Any Additional Complaints? _____

☐ mild ☐ moderate ☐ severe

☐ constant ☐ intermittent

☐ symtoms ⇧ w/activity ☐ symptoms ⇩ w/activity

☐ getting worse ☐ getting better ☐ no change

Treatment received _____

Have you ever received Manual Therapy before?

☐ Y ☐ N Frequency? _____

Are you receiving treatment for other conditions?

☐ Y ☐ N If yes, what are they? _____

Daily activities

Describe how your condition functionally limits the following activities.

Work

Home/Family

Recreational

Check other activities affected: ☐ sleep ☐ washing ☐ dressing ☐ fitness

How do you reduce stress?

In general, do you prefer to sit or stand?

If you're in acute pain, what is your most comfortable position?

Health History (continued on back)

Are you taking any medications? _____

List and explain. Include dates and treatment received.

Surgery _____

Accidents

Major Illnesses

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General

Current | Past | Comments

- ☐ ☐ Headaches
- ☐ ☐ pain
- ☐ ☐ sleep disturbances
- ☐ ☐ fatigue
- ☐ ☐ infections
- ☐ ☐ fever
- ☐ ☐ sinus
- ☐ ☐ other

Skin Conditions

Current | Past | Comments

- ☐ ☐ rashes
- ☐ ☐ athlete's foot
- ☐ ☐ other

Allergies

Current | Past | Comments

- ☐ ☐ scents, oils, lotions
- ☐ ☐ detergents
- ☐ ☐ other

Muscles and Joints

Current | Past | Comments

- ☐ ☐ rheumatoid arthritis
- ☐ ☐ osteoarthritis
- ☐ ☐ osteporosis
- ☐ ☐ scoliosis
- ☐ ☐ broken bones
- ☐ ☐ spinal problems
- ☐ ☐ disc problems
- ☐ ☐ lupus
- ☐ ☐ TMJ, jaw pain
- ☐ ☐ spasms, cramps
- ☐ ☐ sprains, strains
- ☐ ☐ tendonitis, bursitis
- ☐ ☐ stiff or painful joints
- ☐ ☐ weak or sore muscles
- ☐ ☐ neck, shoulder, arm pain
- ☐ ☐ low back, hip, leg pain
- ☐ ☐ other

Nervous System

Current | Past | Comments

- ☐ ☐ head injuries
- ☐ ☐ concussions
- ☐ ☐ dizziness
- ☐ ☐ ringing in ears
- ☐ ☐ loss of memory
- ☐ ☐ confusion
- ☐ ☐ numbness
- ☐ ☐ tingling
- ☐ ☐ sciatica
- ☐ ☐ shooting pain
- ☐ ☐ chronic pain
- ☐ ☐ depression
- ☐ ☐ other

Respiratory & Cardiovascular

Current | Past | Comments

- ☐ ☐ heart disease
- ☐ ☐ blood clots
- ☐ ☐ stroke
- ☐ ☐ lymphedema
- ☐ ☐ high/low blood pressure
- ☐ ☐ irregular heart beat
- ☐ ☐ poor circulation
- ☐ ☐ swollen ankles
- ☐ ☐ varicose veins
- ☐ ☐ chest pain
- ☐ ☐ shortness of breath
- ☐ ☐ asthma
- ☐ ☐ COPD

Cancer/Tumors

Current | Past | Comments

- ☐ ☐ Benign
- ☐ ☐ Malignant

Digestive/Elimination system

Current | Past | Comments

- ☐ ☐ bowel dysfunction
- ☐ ☐ gas, bloating
- ☐ ☐ bladder/kidney dysfunction
- ☐ ☐ abdominal pain
- ☐ ☐ other

Endocrine System

Current | Past | Comments

- ☐ ☐ thyroid dysfunction
- ☐ ☐ diabetes

Reproductive System

Current | Past | Comments

- ☐ ☐ pregnancy
- ☐ ☐ painful menses
- ☐ ☐ fibrotic cysts

Habits

Current | Past | List Frequency

- ☐ ☐ tobacco
- ☐ ☐ alcohol
- ☐ ☐ drugs
- ☐ ☐ coffee
- ☐ ☐ ergogenic aides

Movement & Exercise

Current | Past | List Frequency

- ☐ ☐ Stretching/Yoga
- ☐ ☐ Cardiorespiratory
- ☐ ☐ Strength/Resistance
- ☐ ☐ balance/speed/agility

Contract for Care & Consent for Care

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 *manual therapist* 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 *bodywork/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 *manual therapist* of any changes in my health.

Signature/Date _____ Signature/Date of parent or guardian if patient is a minor. _____