

# Patient Form

## Patient Information:

Full Name: \_\_\_\_\_ Age: \_\_\_\_\_  Female  Male  
Date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ ZIP Code: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Preferred Contact Method:  Phone  Email  Text  
Emergency Contact Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

## What body area(s) are you seeking evaluation for? (check all that apply)

- Neck  Shoulder ( L / R )  Hip ( L / R )  Headache  
 Mid Back  Elbow ( L / R )  Knee ( L / R )  Chest / Ribs  
 Low Back  Wrist / Hand ( L / R )  Ankle / Foot ( L / R )  Abdomen  
 Other: \_\_\_\_\_

## When did your symptoms begin?

- Today  Past week  Past month  1-3 months  
 3-6 months  > 1 year  Unsure  Other: \_\_\_\_\_

## How would you rate the intensity of your symptoms?

- minimal  mild  mild to moderate  
 moderate  moderate to severe  severe

## What is the frequency of your symptoms?

- Rare  Occasional  Intermittent  Frequent  Constant

## How are your symptoms progressing?

- Changes Daily  Improving  Not improving  Worsening

## Describe the symptoms you're experiencing: (please select all that apply)

- Achy  Burning  Numbness/Tingling  Muscle Spasm  
 Sharp  Throbbing  Stiffness  Trouble Sleeping  
 Dull  Radiating  Weakness  Other: \_\_\_\_\_

What self-care treatment have you tried to help symptoms? (please select all that apply)

- Rest
- Stretching
- OTC Medication
- Ice
- Exercise
- TENS
- Other: \_\_\_\_\_
- Heat
- Massage
- None

What physical limitations do you have?

- no limitations
- mild to moderate limitations
- severe limitations
- mild limitations
- moderate limitations
- completely limited

What is your current work status? (select all that apply)

- Working without restrictions
- Missed work due to symptoms
- Not employed
- Working with restrictions
- Currently off work

Cardiovascular (CHECK ONLY IF YES)

- Chest Pain
- Shortness of breath
- Dizziness
- Irregular Heartbeat

Respiratory (CHECK ONLY IF YES)

- Chest tightness
- Chronic cough

Neurologic (CHECK ONLY IF YES)

- Balance Problems
- Weakness
- Numbness/tingling
- Memory Issues
- Speech Difficulty

Musculoskeletal (CHECK ONLY IF YES)

- Back Pain
- Neck Pain
- Joint pain/stiffness
- Muscle aches/spasms
- Leg Pain
- Sciatica

General (CHECK ONLY IF YES)

- Fatigue
- Fever
- Headache
- Sleep disturbance

ENT / Eyes (CHECK ONLY IF YES)

- Vision changes
- Ringing in ears
- Sinus problems
- Sore throat
- Speech Difficulty

### Psychiatric (CHECK ONLY IF YES)

- Anxiety
- Depressed mood

### Genitourinary (CHECK ONLY IF YES)

- Abdominal pain/swelling
- Frequent urination
- Painful urination
- Blood in urine

### Past Medical History (check all that apply)

- High blood pressure
- Diabetes (Type 1 2)
- Stroke
- Cancer (type): \_\_\_\_\_
- Osteoporosis
- Rheumatoid arthritis
- Scoliosis
- Thyroid disease
- Vertigo
- Bleeding disorder
- HIV/AIDS
- Hepatitis
- Pacemaker / Defibrillator
- Other: \_\_\_\_\_

### Problem Areas

**\*Denotes required information**

\*Describe your problem:

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\*On a scale of 0-10, rate your intensity: **Lowest - 1 2 3 4 5 6 7 8 9 10 - Highest**

\*How did your problem begin:

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\*When did your problem begin? (*exact date if possible*)

How often do you experience symptoms: \_\_\_\_\_

**How would you describe your symptoms?**

- Dull
- Aching
- Deep
- Sore
- Stiff
- Tight
- Sharp
- Stabbing
- Shooting
- Cramping
- Spasm
- Throbbing
- Burning
- Numbness
- Tingling
- Weakness

Does it radiate, shoot, or travel to other areas of your body?  Yes  No

If so, to what areas does the pain radiate, shoot, or travel?

\_\_\_\_\_

What makes it **better**? (Times of day, movements, activities, etc):

\_\_\_\_\_

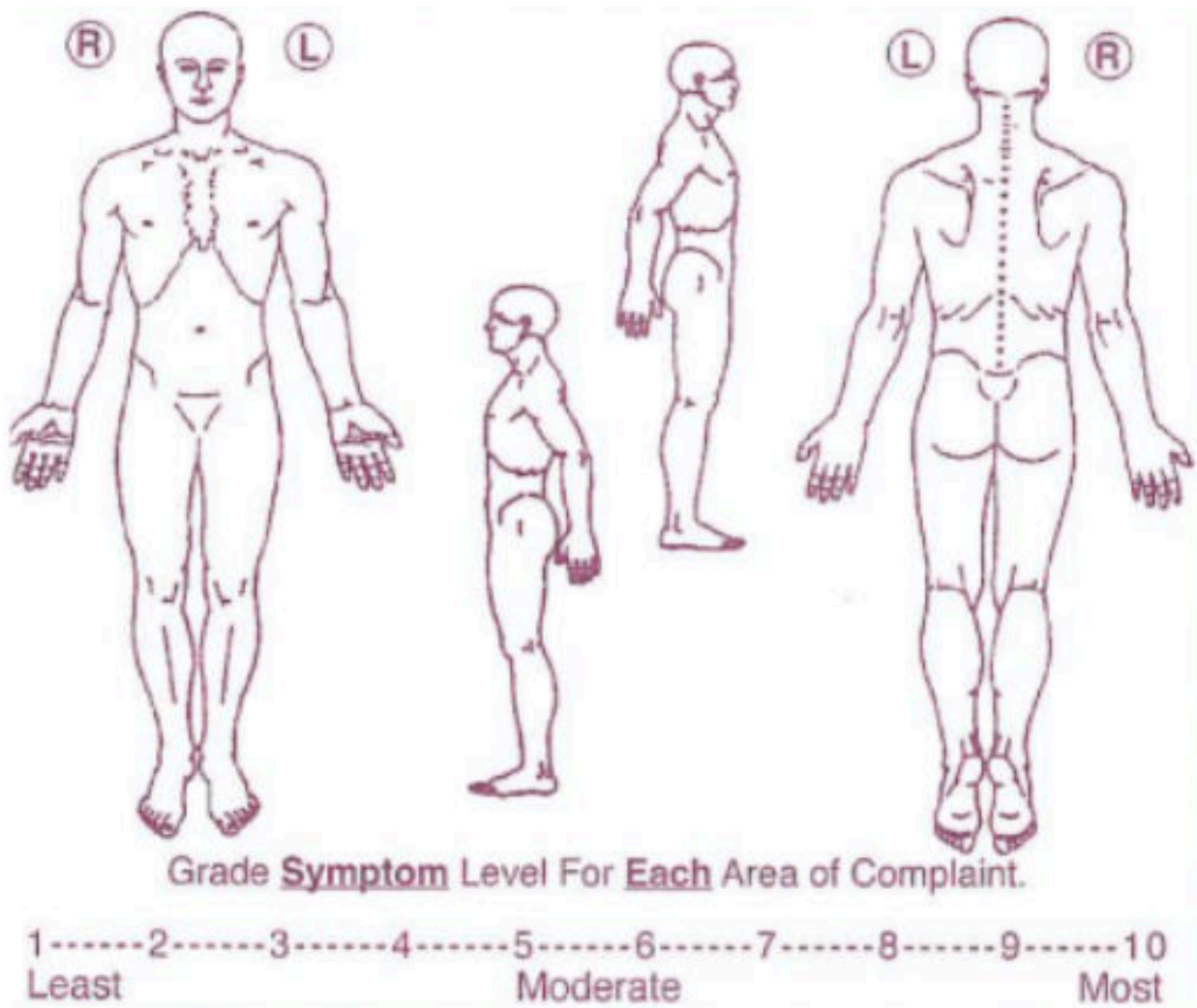
What makes it **worse**? (Times of day, movements, activities, etc):

\_\_\_\_\_

What have you done to relieve the symptoms?

- Ice
- Heat
- Rest
- Sitting
- Lying down
- Stretching
- Exercise
- Prescription Medication
- Over the counter medication
- Massage
- Acupuncture
- Chiropractic Adjustment
- Physical Therapy
- Injections
- Surgery
- Other: \_\_\_\_\_

# Location of Symptoms



Patient/Legal Guardian Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_