Name_____

DOB_____

Patient Information Sheet

DO YOU HAVE OR HAVE YOU EVER HAD…….

YES NO …**PT, ST, or OT OR chiropractic visits this year?** If so, how many?

YES NO …arthritis/problems with bones/joints/muscles?

YES NO …breathing/lung problems?

YES NO …sudden weight gain/loss?

YES NO …unexplained muscle weakness?

YES NO …diabetes?

YES NO …heart problems (angina, high blood pressure, etc.,)

YES NO …cancer?

YES NO …endocrine problems (thyroid, etc.,)

YES NO …other medical problems we should know about?

YES NO …Do you smoke cigarettes? If yes, number of packs/day___for___years.

YES NO …Do you exercise regularly? If yes, how much? _____

YES NO …Are you now pregnant? If yes, due date:_____

YES NO …Are you taking medications? If yes, please list:_____

_____

YES NO …Do you have any allergies? If yes, please list: _____

_____

YES NO …Do you have difficulty controlling your bowel and/or bladder?

What are your goals for therapy?_____

_____

Please indicate your pain levels on the lines below:

Current

No Pain Unbearable Pain

Worst

No pain Unbearable Pain

Best

No Pain Unbearable Pain