

Manual Therapy Associates, Inc

Advanced Hands on Care for A Faster Recovery

Patient Name _____ Date _____

Allergies: List any medication(s) you are allergic to: _____

Current medications / vitamins / supplements: _____

Do you smoke? Yes / No how much: _____ Do you drink alcohol? Yes / No how much _____

Do you consume caffeinated beverages? Yes / no how much: _____

Are you engaged in any regular exercise? Please describe: _____

Are you under a lot of pressure or stress? Yes / no please describe: _____

Do you have a pacemaker, transplanted organ, joint replacement, or metal implants? _____

Have you had any illness in the last 3 weeks (colds, flu, bladder or kidney infection)? _____

Females Only: Are you pregnant or planning a pregnancy? _____

Severe troublesome menstrual cramps? _____

Have you ever been diagnosed with? _____

- Pelvic inflammatory disease
- Endometriosis
- Other gynecological or obstetrical difficulties? _____

Men Only: Do you have history of prostate disease / cancer or infection: _____

Have you ever had any of the following? (check all that apply)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizzy spells | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Scoliosis (curvature of spine) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Increases pain at night | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Skin disorder |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Digestive problems | <input type="checkbox"/> Kidney infection | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood disorder (transferable) | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Latex sensitivity | <input type="checkbox"/> Swelling of neck or glands |
| <input type="checkbox"/> Blood in the stool | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Liver disease | <input type="checkbox"/> TB/Ling disorder |
| <input type="checkbox"/> Bone disease | <input type="checkbox"/> Groin pain/swelling | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Thyroid disorder |
| <input type="checkbox"/> Breast lumps/pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Ulcers / stomach problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Unexplained weight gain/loss |
| <input type="checkbox"/> Chest Pain / pressure / tightening | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Pain or difficulty urinating | <input type="checkbox"/> Urinary infection |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Hernia | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Poor balance | |
| <input type="checkbox"/> Difficulty hearing | <input type="checkbox"/> HIV | <input type="checkbox"/> Ringing in the ears | |

Please explain any positive answer from previous page here: _____

Family History

- | | |
|---|--|
| <input type="checkbox"/> Alcoholism (chemical dependency) | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid disease / dysfunction |

Have you recently noted?

- | |
|--|
| <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Fever / chills / sweats |
| <input type="checkbox"/> Nausea / vomiting |
| <input type="checkbox"/> Numbness / tingling |
| <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Weight gain / loss |

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Key: Pins and Needles = 000000 Stabbing = / / / / / /
 Burning = xxxxxx Deep Ache = zzzzzz

Please rate your current level of pain on the following scale (mark line):

0 1 2 3 4 5 6 7 8 9 10
 (no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (mark line):

0 1 2 3 4 5 6 7 8 9 10
 (no pain) (worst imaginable pain)

Please list 3 activities that you are having difficulty doing or are unable to do. Please rate these activities on following scale.

0 1 2 3 4 5 6 7 8 9 10
 Unable To perform Activity Able to do the same as before injury

Example: Climb Stairs	8		
Activity	Baseline Score	6-week Score	1-year Score

1.

2.

3.

Patient Signature X _____ Date X _____

Therapist Signature X _____ Date X _____

Arvada

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