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?

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

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

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

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

Please explain any positive answer from previous page here: _____

_____

_____

Family History

- ☐ Alcoholism (chemical dependency)
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Kidney disease
- ☐ Mental illness
- ☐ Osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Thyroid disease / dysfunction

Have you recently noted?

- ☐ Fatigue
- ☐ Fever / chills / sweats
- ☐ Nausea / vomiting
- ☐ Numbness / tingling
- ☐ Weakness
- ☐ Weight gain / loss

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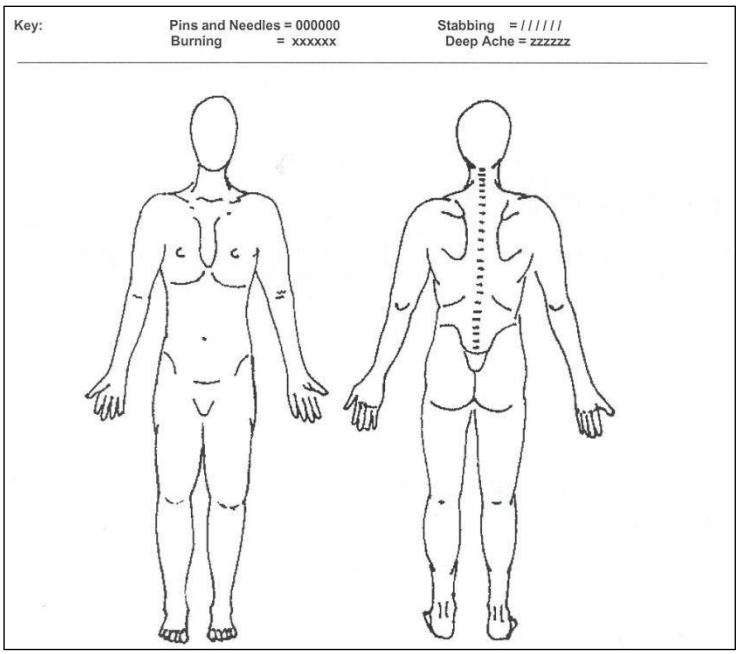

Please rate your current level of pain on the following scale (mark line):

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

Activity	Baseline Score	6-week Score	1-year Score
Example: Climb Stairs	8		
1.			
2.			
3.			

Patient Signature X _____ Date X _____

Therapist Signature X _____ Date X _____

Arvada

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