**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Language(s) Spoken/Understood:**  **English Spanish \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently being seen for another therapy/treatment? YES NO**

If “YES”, please indicate what & where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LATEX ALLERGY: YES NO If “YES” indicate if: Mild Moderate Severe**

**TAPE ALLERGY: YES NO If “YES” indicate if: Mild Moderate Severe**

|  |  |
| --- | --- |
| **SIGNIFICANT MEDICAL CONDITIONS OR SURGICAL PROCEDURES** | |
| **List any SIGNIFICANT medical conditions or surgical procedures here.**  **Note date of onset if known.** | **Date of Onset** |
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| --- | --- | --- | --- |
| **CURRENT MEDICATIONS** | | | |
| **Include prescription or over-the-counter medications, vitamins, herbal products, and respiratory treatments.** | **Dose** | **Frequency** | **Reason** |
|  |  |  |  |
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***Please also complete opposite side 🡪***

|  |  |  |
| --- | --- | --- |
| **Do you have a history of:** | | |
| Cancer? | Yes | No |
| Diabetes? | Yes | No |
| High blood pressure? | Yes | No |
| Heart disease? | Yes | No |
| Angina/chest pain? | Yes | No |
| Stroke? | Yes | No |
| Osteoporosis? | Yes | No |
| Osteoarthritis? | Yes | No |
| Rheumatoid Arthritis? | Yes | No |
| Reflux? | Yes | No |
| Headaches? | Yes | No |
| Kidney Disease? | Yes | No |
| Rheumatic Fever? | Yes | No |
| Ulcers? | Yes | No |
| Contagious diseases? | Yes | No |
| Seizures? | Yes | No |

|  |  |  |
| --- | --- | --- |
| **Have you recently experienced:** | | |
| A change in your health? | Yes | No |
| Nausea/Vomiting? | Yes | No |
| Fever/chills/sweats? | Yes | No |
| Unexplained weight change? | Yes | No |
| Numbness or tingling? | Yes | No |
| Incontinence of bowel/bladder? | Yes | No |
| Shortness of breath? | Yes | No |
| Upper respiratory infection? | Yes | No |
| Urinary tract infection? | Yes | No |
| Open wounds? | Yes | No |
| Swelling? | Yes | No |
| Dizziness? | Yes | No |
| Falls/ Balance problems? | Yes | No |
| (If so how frequently?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

|  |  |  |
| --- | --- | --- |
| **Are you currently:** | | |
| Pregnant? | Yes | No |
| Depressed? | Yes | No |
| Under stress? | Yes | No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Do you have:** | | | | |
| Help/assist if you need it? | | | Yes | No |
| Who can help/assist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Financial or insurance concerns? | | | Yes | No |
| Concerns for your safety due to relationships with others? | | | Yes | No |
| Transportation to appointments? | | | Yes | No |
| Spiritual/cultural practices you would like us to be aware of? | | | Yes | No |
| **I currently have difficulty: (check all that apply)** | | | | |
| Driving | Walking | Standing | | |
| Rising from a chair | | Lifting | | |
| Hearing | Seeing | Communicating | | |
| Dressing or Grooming | | Swallowing | | |
| Reading | Writing | Remembering | | |
| Learning new information/concepts | | | | |
| Other: | | | | |

|  |  |  |
| --- | --- | --- |
| **Is your current problem: (check one)** | | |
| Getting worse | Same | Improving |

|  |  |
| --- | --- |
| **Do you regularly drink alcohol or caffeine?** | |
| Yes \_\_\_\_\_\_\_ drinks/week | No |

|  |  |  |
| --- | --- | --- |
| **Do you smoke/have a history of tobacco use?** | | |
| Yes | No |  |

|  |  |  |
| --- | --- | --- |
| **How often do you exercise (per week)?** | | |
| 0-1 times | 2-3 times | 5-6 times |

|  |
| --- |
| **What are your goals?** |
|  |

|  |
| --- |
| **Mark on the body below where you have pain:** |
| front-back man |

|  |
| --- |
| **Pick a number from 0-10 to describe your pain:** |
| wongfaces |