



Name: _____

DOB: _____

Today's Date: _____

Current Condition:

Describe the problem(s) for which you seek Physical Therapy/Acupuncture/Massage: _____

When did it begin: _____
What happened _____

Have you ever had this problem before? Yes No
How did you treat the problem? _____

Did the problem get better? Yes No
How long did it last _____

What are you doing to care for this problem _____

What makes the problem worse _____

What makes the problem better _____

What are your goals from treatment _____

Have you seen other health care providers for this problem _____

Please **circle** below to rate the intensity of your pain *

At its lowest: 0 1 2 3 4 5 6 7 8 9 10

At its highest: 0 1 2 3 4 5 6 7 8 9 10

Right now: 0 1 2 3 4 5 6 7 8 9 10

* **Please see pain scale attached to the clipboard** *

Have you had any major changes in the last year?
(i.e. Job change, death in family, etc)
 Yes No

General Health

Please rate your general health

Excellent Good Fair Poor

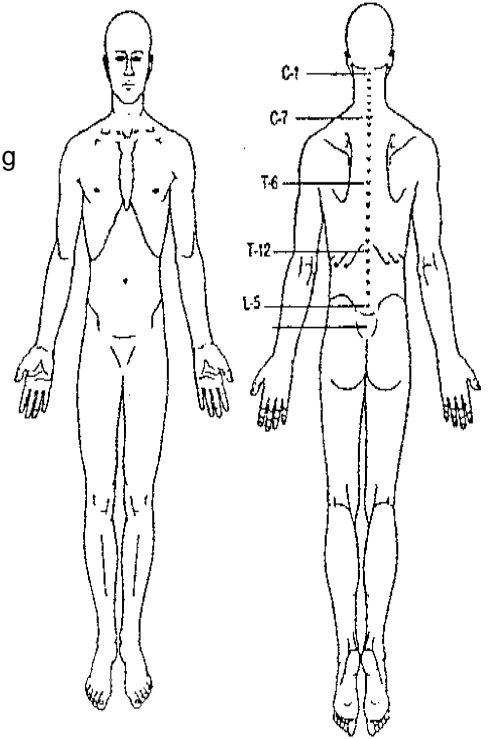
Please mark body area with an:

“X”
for pain/discomfort

“O”
for numbness/tingling

HEIGHT:
_____ , _____”

WEIGHT:
_____ lbs



Social/Health Habits

Smoking

Are you currently using tobacco? Yes No
_____ Cigarettes/Cigars per day
Did you smoke in the past Yes No (yr quit _____)

Alcohol

Days per week you consume alcohol _____
Number of alcoholic drinks per day _____

Exercise

Do you exercise beyond daily activities and chores?
 No Yes How many days per week _____
Describe the exercise _____

Within the past year, have you had any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Loss of Appetite |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Bowel Problems |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Weight Loss/Gain |
| <input type="checkbox"/> Dizziness/Blackouts | <input type="checkbox"/> Urinary Problems |
| <input type="checkbox"/> Coordination Problems | <input type="checkbox"/> Fever/Chills |
| <input type="checkbox"/> Weakness in Arms or Legs | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Falls/Loss of Balance | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Difficulty Walking | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Joint Pain or Swelling | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> Pain at Night | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Difficulty Sleeping | |



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Medical History

Please check if you have ever had the following:

- | | |
|---|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Infectious Disease |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Ankylosing Spondy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Auto Immune Disorder | <input type="checkbox"/> Spondylolisthesis |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Low Blood Sugar |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Developmental Problems | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Fibroids | <input type="checkbox"/> Parkinson Disease |
| <input type="checkbox"/> Gastric Reflux | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Herpes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Urinary leakage |
| <input type="checkbox"/> | <input type="checkbox"/> Urinary difficulty |

Family Health

Indicate whether any family member has had the following, and date of onset, if known:

- Heart Disease _____
- Hypertension _____
- Stroke _____
- Diabetes _____
- Cancer _____
- Psychological _____
- Arthritis _____
- Osteoporosis _____

Please List Type and Date of Surgeries, Epidural Blocks or Trigger Point Injections: _____

_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Diagnostic Tests

Within the past year, have you had any of the following tests?

- | | |
|---|---|
| <input type="checkbox"/> Angiogram | <input type="checkbox"/> Mammogram |
| <input type="checkbox"/> Arthroscopy | <input type="checkbox"/> MRI |
| <input type="checkbox"/> Biopsy | <input type="checkbox"/> Myelogram |
| <input type="checkbox"/> Blood Tests | <input type="checkbox"/> NCV |
| <input type="checkbox"/> Bone Scan | <input type="checkbox"/> Pap Smear |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Pulmonary Function |
| <input type="checkbox"/> CT Scan | <input type="checkbox"/> Spinal tap |
| <input type="checkbox"/> Doppler ultrasound | <input type="checkbox"/> Stool Test |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Stress Test |
| <input type="checkbox"/> EEG | <input type="checkbox"/> Urine Test |
| <input type="checkbox"/> EKG | <input type="checkbox"/> X-ray |
| <input type="checkbox"/> EMG | <input type="checkbox"/> Other _____ |

Mental Health

Over the last 2 weeks, how often have you been bothered by any of the following:

Little interest or pleasure in doing things?

- Not at all – 0
- Several Days – 1
- More than half the days – 2
- Nearly every day – 3

Feeling down, depressed or hopeless?

- Not at all – 0
- Several Days – 1
- More than half the days – 2
- Nearly every day – 3

Have you ever been diagnosed with Depression, Anxiety, Bi-Polar or other? Yes No

Are you currently taking medication for your Diagnosis? Yes No

Women Only: Have you been diagnosed with:

- Pelvic Inflammatory Disease
- Endometriosis
- Trouble with your period
- Pregnancy Complications
- Pregnant or might be pregnant
- Other OB/GYN difficulties
- Pregnancy & Deliveries _____

Acupuncture

Have you ever had acupuncture?

- Yes No

Are you currently taking blood thinners?

- Yes No

Questions regarding acupuncture _____

