Patient Name: DOB:

Medical Information

Injury, onset or change of status Date:_____Have you experienced similar symptoms in the past? Yes No

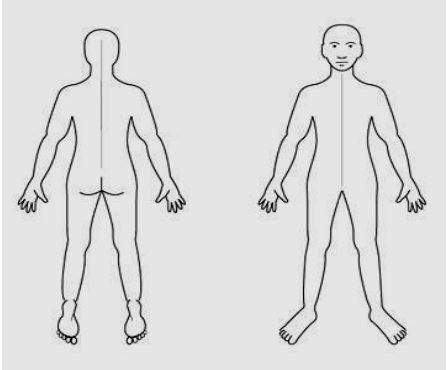
Primary Concern/Chief Complaint:_____

Are your symptoms due to a new injury? Y N **How did you become injured?**_____

_____

Previous surgery or hospitalization for this injury? (Please list)_____

On the diagram below please indicate where you are experiencing <u>Pain/discomfort</u> with *XXX*
<u>Numbness/tingling</u> with ///



PAIN SCALE 0-------1-------2-------3-------4-------5-------6-------7-------8-------9-------10

NO Discomfort — WORST PAIN IMAGINABLE

Based on the pain scale above, please indicate what number your pain is at when;

Best_____ Current_____ Worst_____

Please check any of the following that cause your symptoms to worsen.

☐ Sitting ☐ Standing ☐ Walking ☐ Stairs-up ☐ Stairs-down
☐ Bending ☐ Voiding ☐ Lying Down ☐ Cough/sneeze ☐ Sit to stand

What improves your symptoms? ☐ Ice ☐ Heat ☐ Medication ☐ Other_____

Nature of Symptoms/Pain You Are Currently Experiencing (*circle all that apply)*

Sharp Shooting Dull Ache Burning Tightness Throbbing

Frequency of Symptoms. Please circle the option below that best describes how often you are experiencing symptoms

Constant (76-100% of the day) Frequently (51-75% of the day) Occasionally (26-50% of the day) Intermittently (0-25% of the day)

Patient Name: DOB:

MEDICAL INFORMATION

What is your occupation?_____**Tobacco user/smoker?** Yes No

Have you had any falls in the last year? Yes No **If yes, how many?**_____ **Were there any injuries with the falls?** Yes No

Please check any of the following symptoms you are currently experiencing that are new or unusual.

☐ Unexplained weight loss/gain	☐ Memory Issues	☐ Weakness
☐ Nausea/vomiting	☐ Dizziness	☐ Vision Problems
☐ Leakage with activity	☐ Difficulty Swallowing	☐ Insomnia
☐ Loss of bowel/bladder control	☐ Swelling	☐ Fatigue

Are you, or have you ever been treated for any of the following? (Check all that apply)

☐ Heart Disease	☐ Fractures	☐ Osteoarthritis	☐ Kidney Issues
☐ Stroke	☐ High Blood Pressure	☐ Parkinson's Disease	☐ Thyroid Issues
☐ Diabetes	☐ Cancer	☐ Rheumatoid Arthritis	☐ Depression
☐ Fibromyalgia	☐ Obesity	☐ Traumatic Brain Injury	☐ Asthma

How much caffeine do you consume daily?_____ **Do you drink alcohol?** Yes No

Are you allergic to latex? Yes No **Are you allergic to beeswax?** Yes No **Are you allergic to Coconut oil?** Yes No

Any other allergies? If yes please list_____

Are you taking blood thinners or aspirin? Yes No **Do you have a pacemaker?** Yes No **Are you pregnant**? Yes No

Do you have an intra-uterine device (IUD)? Yes No **Do you have a DNR order in place?** Yes No

Please list any previous surgeries and the dates when they occurred._____

_____

List of medications including prescription, over-the-counter, herbals, and vitamin/mineral/dietary (nutritional) supplements

Medications	Dosage	Frequency	Route of Admin: (oral, topical, etc)	Changes (Office Use)	Date of Changes (Office Use)

Patient Name: DOB:

Medical Information

How would you rate your general health? *(Circle one)* Good Fair Poor

Home Layout: *(Check all that apply)*

- ☐ 1-story
- ☐ 2 - story
- ☐ Apartment/condo
- ☐ Wheelchair accessible
- ☐ Stairs/step
- ☐ Shower stall
- ☐ Bath/shower combo

Social History: *(Circle one)* Married Single Divorced Widowed

Living arrangements: *(Circle one)* Lives alone Lives with family Lives with caregiver Lives at assisted living facility