Provider Name

HEALTH INFORMATION

Patient Name _____ Date _____

Date of Injury _____ Insurance ID# _____

A. Patient Information

Address _____

City _____ State ____ Zip _____

Phone: Home _____

Work _____ Cell/Pgr _____

Date of Birth _____

Employer _____

Occupation _____

Emergency Contact _____

Phone: Home _____

Work _____ Cell/Pgr _____

Primary Health Care Provider

Name _____

Address _____

City/State/Zip _____

Phone: _____ Fax _____

I give my manual therapist permission to consult with my referring health care provider regarding my health and treatment.

Comments _____

Initials _____ Date _____

B. Current Health Information

List Health/Concerns Check all that apply

Primary _____

☐ mild ☐ moderate ☐ disabling
☐ constant ☐ intermittant
☐ symptoms ↑ w/activity ☐ ↓ w/activity
☐ getting worse ☐ getting better ☐ no change
treatment received _____

Secondary _____

☐ mild ☐ moderate ☐ disabling
☐ constant ☐ intermittant
☐ symptoms ↑ w/activity ☐ ↓ w/activity
☐ getting worse ☐ getting better ☐ no change
treatment received _____

Additional _____

☐ mild ☐ moderate ☐ disabling
☐ constant ☐ intermittant
☐ symptoms ↑ w/activity ☐ ↓ w/activity
☐ getting worse ☐ getting better ☐ no change
treatment received _____

Have you ever received Manual Therapy before? ☐ Y ☐ N Frequency? _____

List all conditions currently monitored by a Health Care Provider _____

List the medications you took today (include pain relievers and herbal remedies)

List all other medications taken in the last 3 months _____

List Daily Activities

Work _____

Home/Family _____

Social/Recreational _____

Circle the activities affected by your condition,
☐ all of the above
Check other activities affected: ☐ sleep
☐ washing ☐ dressing ☐ fitness

How do you reduce stress? _____

Pain? _____

What are your goals for receiving Manual Therapy? _____

C. Health History

List and Explain. Include dates and treatment received.

Surgeries _____

Accidents _____

Major Illnesses _____