

Manual Therapy Associates, Inc

Advanced Hands on Care for A Faster Recovery

Intake Form

Patient Name _____ Date _____

Employment/work (circle one) work full-time / part-time / home maker / student / retired / unemployed / or off work because of injury

Allergies: List any medication(s) you are allergic to: _____

Are you latex sensitive? Yes / no List any other allergies we should know about: _____

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? _____

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

Men Only: Do you have history of prostate disease / cancer or infection? _____

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

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

12001 W. 63rd Place,
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Lafayette 80026

3885 Upham St.
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Phone: 303-936-4767 Fax: 303-936-3828

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Patient Name _____

Please explain any positive answer from previous page here: _____

Family History

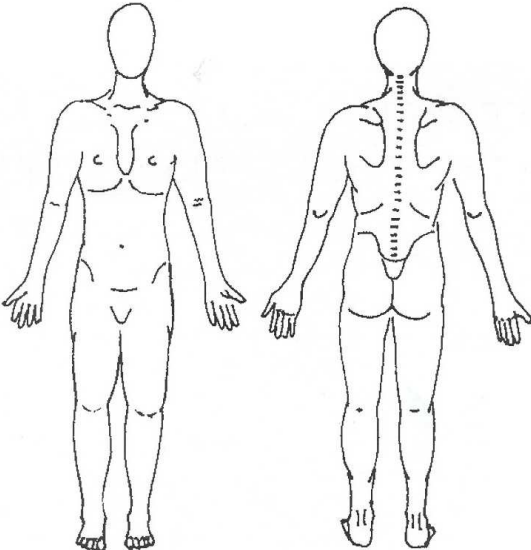
- Alcoholism (chemical dependency)
- Diabetes
- Cancer
- Heart attack
- High blood pressure
- Heart disease

- 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

Key: Pins and Needles = 000000
Burning = xxxxxx
Stabbing = /////
Deep Ache = zzzzzz



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)

Patient Signature X Date X

Therapist Signature X Date X

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