Manual Therapy Associates, Inc

Advanced Hands on Care for A Faster Recovery

Patient Name ______________________________ Date______________

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

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?

- O *Pelvic inflammatory disease*
- O *Endometriosis*
- O *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)

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

Please explain any positive answer from previous page here: ______________________________

____

____

Family History

- O Alcoholism (chemical dependency)
- O Diabetes
- O Cancer
- O Heart attack
- O High blood pressure
- O Heart disease
- O Kidney disease
- O Mental illness
- O Osteoporosis
- O Rheumatoid arthritis
- O Stroke
- O Thyroid disease / dysfunction

Have you recently noted?

- O Fatigue
- O Fever / chills / sweats
- O Nausea / vomiting
- O Numbness / tingling
- O Weakness
- O Weight gain / loss

Arvada Golden

Phone: 303-456-2671 Fax: 303-456-0220

Manual Therapy Associates, Inc

Advanced Hands on Care for A Faster Recovery

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)

Please list 3 activities that you are having difficulty doing or are unable to do. Please rate these activities on following scale.

0	1	2	3	4	5	6	7	8	9	10
Unable To perform Activity										Able to do the same as before injury

Example: Climb Stairs 8

Activity	Baseline Score	6-week Score	1-year Score
1.			
2.			
3.			

Patient Signature X______________________ Date X__________

Therapist Signature X______________________ Date X__________

Arvada Golden
Phone: 303-456-2671 Fax: 303-456-0220