**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Language(s) Spoken/Understood:**  **English Spanish \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you currently being seen for another therapy/treatment? YES NO**

If “YES”, please indicate what & where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LATEX ALLERGY: YES NO If “YES” indicate if: Mild Moderate Severe**

**TAPE ALLERGY: YES NO If “YES” indicate if: Mild Moderate Severe**

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| **SIGNIFICANT MEDICAL CONDITIONS OR SURGICAL PROCEDURES** |
| **List any SIGNIFICANT medical conditions or surgical procedures here.** **Note date of onset if known.** | **Date of Onset** |
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| **CURRENT MEDICATIONS** |
| **Include prescription or over-the-counter medications, vitamins, herbal products, and respiratory treatments.**  | **Dose** | **Frequency** | **Reason** |
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***Please also complete opposite side 🡪***

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| **Do you have a history of:** |
| Cancer? | Yes | No |
| Diabetes?  | Yes | No |
| High blood pressure? | Yes | No |
| Heart disease? | Yes | No |
| Angina/chest pain? | Yes | No |
| Stroke? | Yes | No |
| Osteoporosis?  | Yes | No |
| Osteoarthritis? | Yes | No |
| Rheumatoid Arthritis? | Yes | No |
| Reflux? | Yes | No |
| Headaches? | Yes | No |
| Kidney Disease? | Yes | No |
| Rheumatic Fever? | Yes | No |
| Ulcers? | Yes | No |
| Contagious diseases? | Yes | No |
| Seizures? | Yes | No |

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| **Have you recently experienced:** |
| A change in your health? | Yes | No |
| Nausea/Vomiting? | Yes | No |
| Fever/chills/sweats?  | Yes | No |
| Unexplained weight change? | Yes | No |
| Numbness or tingling?  | Yes | No |
| Incontinence of bowel/bladder? | Yes | No |
| Shortness of breath? | Yes | No |
| Upper respiratory infection? | Yes | No |
| Urinary tract infection? | Yes | No |
| Open wounds? | Yes | No |
| Swelling? | Yes | No |
| Dizziness? | Yes | No |
| Falls/ Balance problems? | Yes | No |
| (If so how frequently?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Are you currently:** |
| Pregnant? | Yes | No |
| Depressed? | Yes | No |
| Under stress? | Yes | No |

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| **Do you have:** |
| Help/assist if you need it? | Yes | No |
| Who can help/assist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Financial or insurance concerns? | Yes | No |
| Concerns for your safety due to relationships with others? | Yes | No |
| Transportation to appointments? | Yes | No |
| Spiritual/cultural practices you would like us to be aware of? | Yes | No |
| **I currently have difficulty: (check all that apply)** |
|  Driving |  Walking |  Standing |
|  Rising from a chair |  Lifting |
|  Hearing |  Seeing |  Communicating |
|  Dressing or Grooming |  Swallowing |
|  Reading |  Writing |  Remembering |
|  Learning new information/concepts |
| Other: |

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| **Is your current problem: (check one)** |
|  Getting worse |  Same |  Improving |

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| **Do you regularly drink alcohol or caffeine?** |
|  Yes \_\_\_\_\_\_\_ drinks/week |  No |

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| **Do you smoke/have a history of tobacco use?** |
|  Yes |  No |  |

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| **How often do you exercise (per week)?** |
|  0-1 times |  2-3 times |  5-6 times |

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| **What are your goals?** |
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| **Mark on the body below where you have pain:** |
| front-back man |

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| **Pick a number from 0-10 to describe your pain:** |
| wongfaces |