Name: _____ Date of Birth:

_____ Address:_____

City:_____ State: _____ Zip Code:_____

Best Contact Phone Number :_____ (Cell / Home)

Referring Physician or Primary Doctor: _____

Hand Dominance: □ Right □ Left

How did you hear about our services? □ Doctor □ Nurse practitioner/PA □ Chiropractor □ Friend/family
□ Internet □ Other: _____
*Your email address: (optional)
Your email is used share information about your diagnosis, appointment reminders, healthy lifestyle tips, and monthly newsletters …

WORK INFORMATION
Are you currently employed? □ Yes □ No
What is your job title/position? _____
What are your job duties/responsibilities? _____
_____

What is your work status?					
	□ Full-duty	□ Full-time	□ Part-time	□ Restrictions	□ Retired
	□ Light-duty	□ One-handed	□ Off-duty	□ Disability	□ Student

PAST MEDICAL HISTORY
Please circle any past or current medical problems you may have:

Cardiac Heart Failure	◯	Cancer	☐	Stroke	☐
Pacemaker	◯	High Blood Pressure	☐	Head Injury	☐
Cardiovascular Disease	◯	Diabetes	☐	Neck or Back pain	☐
COPD	◯	Gout	☐		
Irregular Heart rate	◯	Arthritis	☐		

Other (please list): _____

Check if you consume □ tobacco/nicotine □ cannabis. Have you fallen in the last 6 months? □ Yes □ No

Please list any previous neck, shoulder, arm, and/or hand surgeries and/or injuries:_____

_____

Do you have any metal implants or artificial joints? □ Yes □ No

Do you have any allergies? Please specify: _____

Are you taking any medications? Please list: _____

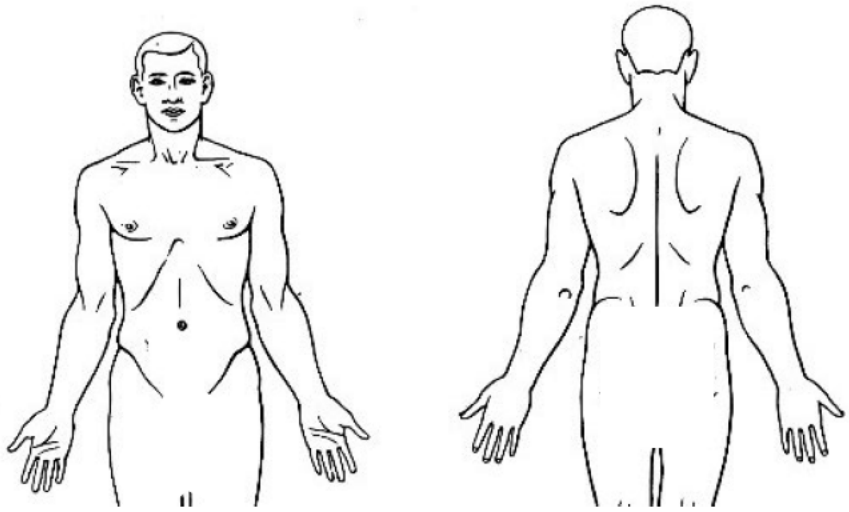
_____

Have you had any of the following tests performed for your current problem:

Test			***Results:***
X-rays	□ Yes	□ No	_____
Nerve conduction test	□ Yes	□ No	_____
EMG	□ Yes	□ No	_____
CT Scan	□ Yes	□ No	_____
MRI	□ Yes	□ No	_____

SYMPTOMS

Please use this diagram to circle any problem areas:



PAIN

On a scale of 0 – 10, circle the number that best describes the intensity of your worst pain in the last week.
0 = no pain, to 10 = worst pain you could imagine.

0 1 2 3 4 5 6 7 8 9 10

TELL US ABOUT YOUR CURRENT CONDITION…

Date of injury: _____

Date of surgery: _____

What happened? Briefly describe your current problem/symptoms: _____

_____

Have you ever had these symptoms before? When? _____

Previous treatment for this problem? _____

What makes it better? _____

What makes it worse? _____

Have you tried any devices or orthoses? _____

How does this impact your life? What can't you do as a result? _____

_____

What hobbies/recreational activities do you enjoy? Are you having any difficulties performing these activities?

_____

What are your goals in coming to therapy? _____

_____

THANK YOU!