

Name _____
DOB _____

**Patient Information Sheet**

DO YOU HAVE OR HAVE YOU EVER HAD.....

- YES NO ...**Physical Therapy or Chiropractic visits this year?** If so, how many?
- YES NO ...arthritis/problems with bones/joints/muscles?
- YES NO ...breathing/lung problems?
- YES NO ...sudden weight gain/loss?
- YES NO ...unexplained muscle weakness?
- YES NO ...diabetes?
- YES NO ...heart problems (angina, high blood pressure, etc.,)
- YES NO ...cancer?
- YES NO ...endocrine problems (thyroid, etc.,)
- YES NO ...other medical problems we should know about?
- YES NO ...Do you smoke cigarettes? If yes, number of packs/day\_\_\_for\_\_\_years.
- YES NO ...Do you exercise regularly? If yes, how much? \_\_\_\_\_
- YES NO ...Women: Are you now pregnant? If yes, due date: \_\_\_\_\_
- YES NO ...Are you taking medications? If yes, please list: \_\_\_\_\_

---

YES NO ...Do you have any allergies? If yes, please list: \_\_\_\_\_

---

YES NO ...Do you have difficulty controlling your bowel and/or bladder?

What are your goals for therapy? \_\_\_\_\_

---

Please indicate your pain levels on the lines below:

<b>Current</b>	-----
	No Pain <span style="float: right;">Unbearable Pain</span>
<b>Worst</b>	-----
	No pain <span style="float: right;">Unbearable Pain</span>
<b>Best</b>	-----
	No Pain <span style="float: right;">Unbearable Pain</span>