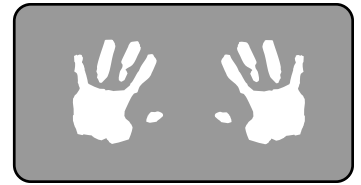


Your Name: \_\_\_\_\_

Email: \_\_\_\_\_

PJ Harris, LMP



Provider Name \_\_\_\_\_

## HEALTH INFORMATION

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Injury \_\_\_\_\_ Insurance ID# \_\_\_\_\_

### A. Patient Information

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone: Home \_\_\_\_\_

Work \_\_\_\_\_ Cell/Pgr \_\_\_\_\_

Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone: Home \_\_\_\_\_

Work \_\_\_\_\_ Cell/Pgr \_\_\_\_\_

#### Primary Health Care Provider

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax \_\_\_\_\_

I give my manual therapist permission to consult with my referring health care provider regarding my health and treatment.

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_\_

### B. Current Health Information

List Health/Concerns Check all that apply

Primary \_\_\_\_\_

mild  moderate  disabling

constant  intermittent

symptoms ↑ w/activity  ↓ w/activity

getting worse  getting better  no change  
treatment received \_\_\_\_\_

Secondary \_\_\_\_\_

mild  moderate  disabling

constant  intermittent

symptoms ↑ w/activity  ↓ w/activity

getting worse  getting better  no change  
treatment received \_\_\_\_\_

Additional \_\_\_\_\_

mild  moderate  disabling

constant  intermittent

symptoms ↑ w/activity  ↓ w/activity

getting worse  getting better  no change  
treatment received \_\_\_\_\_

Have you ever received Manual Therapy before?  Y  N Frequency? \_\_\_\_\_

List all conditions currently monitored by a Health Care Provider \_\_\_\_\_

List the medications you took today (include pain relievers and herbal remedies)

List all other medications taken in the last 3 months \_\_\_\_\_

#### List Daily Activities

Work \_\_\_\_\_

Home/Family \_\_\_\_\_

Social/Recreational \_\_\_\_\_

Circle the activities affected by your condition,  
 all of the above

Check other activities affected:  sleep

washing  dressing  fitness

How do you reduce stress? \_\_\_\_\_

Pain? \_\_\_\_\_

What are your goals for receiving Manual Therapy? \_\_\_\_\_

### C. Health History

List and Explain. Include dates and treatment received.

Surgeries \_\_\_\_\_

Accidents \_\_\_\_\_

Major Illnesses \_\_\_\_\_

**General**

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	headaches _____
<input type="checkbox"/>	<input type="checkbox"/>	pain _____
<input type="checkbox"/>	<input type="checkbox"/>	sleep disturbances _____
<input type="checkbox"/>	<input type="checkbox"/>	fatigue _____
<input type="checkbox"/>	<input type="checkbox"/>	infectious _____
<input type="checkbox"/>	<input type="checkbox"/>	fever _____
<input type="checkbox"/>	<input type="checkbox"/>	sinus _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

**Skin Conditions**

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	rashes _____
<input type="checkbox"/>	<input type="checkbox"/>	athlete's foot, warts _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

**Allergies**

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	scents, oils, lotions _____
<input type="checkbox"/>	<input type="checkbox"/>	detergents _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

**Muscles and Joints**

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	rheumatoid arthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	osteoarthritis _____
<input type="checkbox"/>	<input type="checkbox"/>	osteoporosis _____
<input type="checkbox"/>	<input type="checkbox"/>	scoliosis _____
<input type="checkbox"/>	<input type="checkbox"/>	broken bones _____
<input type="checkbox"/>	<input type="checkbox"/>	spinal problems _____
<input type="checkbox"/>	<input type="checkbox"/>	disk problems _____
<input type="checkbox"/>	<input type="checkbox"/>	lupus _____
<input type="checkbox"/>	<input type="checkbox"/>	TMJ, jaw pain _____
<input type="checkbox"/>	<input type="checkbox"/>	spasms, cramps _____
<input type="checkbox"/>	<input type="checkbox"/>	sprains, strains _____
<input type="checkbox"/>	<input type="checkbox"/>	tendonitis, bursitis _____
<input type="checkbox"/>	<input type="checkbox"/>	stiff or painful joints _____
<input type="checkbox"/>	<input type="checkbox"/>	weak or sore muscles _____
<input type="checkbox"/>	<input type="checkbox"/>	neck, shoulder, arm pain _____
<input type="checkbox"/>	<input type="checkbox"/>	low back, hip, leg pain _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

**Nervous System**

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	head injuries, concussions _____
<input type="checkbox"/>	<input type="checkbox"/>	dizziness, ringing in the ears _____
<input type="checkbox"/>	<input type="checkbox"/>	loss of memory, confusion _____
<input type="checkbox"/>	<input type="checkbox"/>	numbness, tingling _____
<input type="checkbox"/>	<input type="checkbox"/>	sciatica, shooting pain _____
<input type="checkbox"/>	<input type="checkbox"/>	chronic pain _____
<input type="checkbox"/>	<input type="checkbox"/>	depression _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

**Respiratory, Cardiovascular**

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	heart disease _____
<input type="checkbox"/>	<input type="checkbox"/>	blood clots _____
<input type="checkbox"/>	<input type="checkbox"/>	stroke _____
<input type="checkbox"/>	<input type="checkbox"/>	lymphadema _____
<input type="checkbox"/>	<input type="checkbox"/>	high, low blood pressure _____
<input type="checkbox"/>	<input type="checkbox"/>	irregular heart beat _____
<input type="checkbox"/>	<input type="checkbox"/>	poor circulation _____
<input type="checkbox"/>	<input type="checkbox"/>	swollen ankles _____
<input type="checkbox"/>	<input type="checkbox"/>	varicose veins _____
<input type="checkbox"/>	<input type="checkbox"/>	chest pain, shortness of breath _____
<input type="checkbox"/>	<input type="checkbox"/>	asthma _____

**Digestive/ Elimination System**

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	bowel dysfunction _____
<input type="checkbox"/>	<input type="checkbox"/>	gas, bloating _____
<input type="checkbox"/>	<input type="checkbox"/>	bladder/kidney dysfunction _____
<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain _____
<input type="checkbox"/>	<input type="checkbox"/>	other _____

**Endocrine System**

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	thyroid dysfunction _____
<input type="checkbox"/>	<input type="checkbox"/>	diabetes _____

**Reproductive System**

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	pregnancy _____
<input type="checkbox"/>	<input type="checkbox"/>	painful, emotional menses _____
<input type="checkbox"/>	<input type="checkbox"/>	fibrotic cysts _____

**Cancer/Tumors**

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	benign _____
<input type="checkbox"/>	<input type="checkbox"/>	malignant _____

**Habits**

current	past	comments
<input type="checkbox"/>	<input type="checkbox"/>	tobacco _____
<input type="checkbox"/>	<input type="checkbox"/>	alcohol _____
<input type="checkbox"/>	<input type="checkbox"/>	drugs _____
<input type="checkbox"/>	<input type="checkbox"/>	coffee, soda _____

**Contract for Care**

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

**Consent for Care**

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent or guardian \_\_\_\_\_ Date \_\_\_\_\_  
(If patient is a minor)