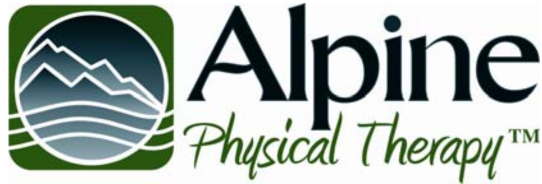


# Client Information

## General Information

Name ______________________________ Age _______ Gender M F

Physician ___________________________ Email address _________________

How were you referred to us? ____ Physician, ______________ Friend (name),

____ Phonebook (Dex, Bear, Blackfoot), ____ The Peak, ____ Missoulian,

_________________________________Other. Are you a previous patient? Y N

## History

Occupation __________________________________________________________

Currently working? Y N Hours per week ____________________________

Handedness R L Tobacco use Y N Amount/day ___________________

## Past Medical History (Please circle and provide dates and information)

Diabetes/hypo/hyperglycemia ___________________________________________

High/low blood pressure ___________________________________________

Cancer ___________________________________________

Stroke ___________________________________________

Osteoporosis ___________________________________________

Osteo/rheumatoid arthritis ___________________________________________

Broken bones ___________________________________________

Surgeries ___________________________________________

Vision/hearing problems ___________________________________________

Dizziness/fainting/seizures ___________________________________________

Heart condition/pacemaker ___________________________________________

Injury to head, chest, organs ___________________________________________

Depression ___________________________________________

Mental condition ___________________________________________

Lung disorders ___________________________________________

Asthma/difficulty breathing ___________________________________________

Swelling/joint pain ___________________________________________

Headaches ___________________________________________

Night pain ___________________________________________

Severe illness __________________________________________

Other ___________________________________________

Medications (list) ___________________________________________

**Continued on next page**

## History of Your Current Condition

What are we treating you for? ____________________

When did it start? ____________________

How did it happen? ____________________

Has anything helped? ____________________

What makes it worse? ____________________

Medical tests (X-rays, MRI, etc.) ____________________

Have you had physical therapy before? ____________________

Rate your pain (0-10) Now __________ Worst __________ Best __________

Rate your ability to do things (1-100%) ____________________

Recreational activities ____________________

## Please mark your pain symptoms below.

(A: Ache S: Stabbing R: Radiating P: Pins and Needles O: Other)