



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) _____

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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)

