**Patient Health History Form – MANUAL THERAPY**

In order to provide you the best possible wellness care, please complete this form before any treatment is rendered.

All information is strictly CONFIDENTIAL.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_# Hours/Week Currently Working: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check off any of the following symptoms you have experienced in the last 6 months:**

* Low Back Pain
* Pain between Shoulder Blades
* Neck Pain/Shoulder Tension
* Tension/Headaches
* Numbness/Tingling – Hands/Fingers
* Pregnancy\_\_\_\_\_\_\_\_Weeks
* Pain in the legs
* Pain in the feet
* Tired/Fatigued
* Fibromyalgia
* **Surgery**
* Digestive Problems
* Carpal Tunnel
* Numbness/Tingling in Legs/Feet

Other (explain): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Which of the above is worst? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often does it occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.What does it feel like? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long have you had it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. What have you done that has helped this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does this cause you to be?**

* Moody
* Irritable
* Interrupt sleep
* Restricted in your daily activities

**Does this affect your work?**

* Poor Attitude
* Decision making
* Decreased productivity
* Exhausted at the end of the day

**Does this affect your life?**

* Lose patience with spouse/children
* Restricted household duties
* Hinders ability to exercise or sports
* Interferes with ability to do hobbies or other activities

**What have you tried to help relieve/get rid of this problem and how much did it help? (Circle appropriately)**

* Medications: Little Some Much
* Physical Therapy: Little Some Much
* Chiropractic: Little Some Much **OTHER**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Exercise: Little Some Much
* Nutrition: Little Some Much
* Stretching: Little Some Much
* Are you under Chiropractic care? **YES NO** (explain why) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Due to our success of eliminating the problems stated above, would it interest you to resolve these symptoms permanently? **YES NO**
* Would you consider treatment in our office as a proactive approach to living symptom/pain free? **YES NO**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please take a moment and carefully read the following information, and sign where indicated.**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Print Name) understand that the manual therapy I receive is provided for the basic purpose of relaxation, stress reduction, and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner. If trigger points are found (which indicates undetected nerve damage) a solution by the Doctor will be given.

I further understand that manual therapy should not be construed as a substitute for medical examination, diagnosis, or treatment and I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment that I am aware of. Manual Therapy is contraindicated (should not be done) under certain medical conditions, I affirm that I have stated all known medical conditions, and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile, and understand that there shall be no liability on the practitioner’s part should I forget to do so.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**