



CLINICAL INTAKE INFORMATION

Patient Name _____

Date _____

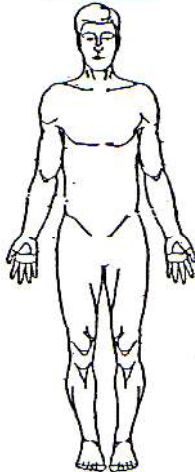
Please complete the following information in detail. This will assist us in designing the most effective and efficient individualized program for you. Every item is significant and important.
Thank you for your effort.

Who recommended you to this office? _____

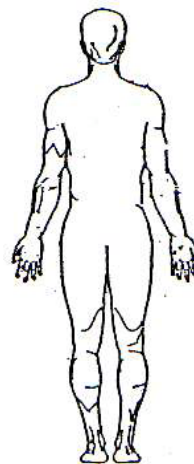
Official Diagnosis: _____

Pain Diagram: Please shade **all** areas of pain. Be thorough and specific.
Indicate the severity of pain on a scale of 0 = none to 10 = severe (excruciating) pain.

FRONT

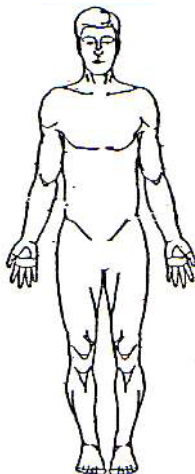


BACK

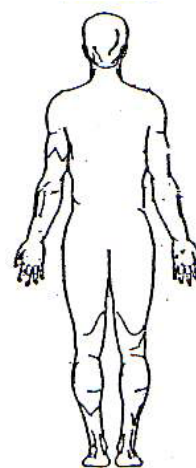


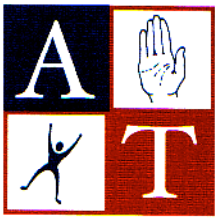
Parasthesia Diagram: Please shade **all** areas of “funny feelings” (tingling, burning, pins and needles, etc.)

FRONT



BACK





CURRENT ISSUES

Please describe your current problem, pain or disability that you are seeking treatment for:

When did your pain or disability begin? (weeks/months/years)_____

Was your onset of pain or disability sudden? gradual? Please explain:

Please describe how your present living situation is different from the way it was before you first experienced pain/disability problems:

WORK/ OCCUPATION/ FUNCTION

Please state what you do for a living: _____

If you are currently not working:

How long have you not worked? _____

Are you not working for reasons other than your pain problem? _____

If so, what reason? _____

Hours per week at a paying job: Before pain/disability After pain/disability
Hours per week doing household chores: _____

How many hours do you sleep at night? _____

How many hours per day do you spend out of bed? _____

How would you consider your present level of activity? ___poor ___fair ___good

Please list your present hobbies: _____

Describe any regular exercise or sport you presently do: _____



MEDICAL HISTORY

Please list any other current medical issues (illnesses, diseases, fractures):

Please list any past medical issues (illnesses, diseases, fractures):

Please list all operations you have undergone and approximate dates:

Please list all traumas, falls, accidents and injuries you have experienced in your life:

Please list all prescription medication or nutritional supplements you are taking:

Please list all medication or nutritional supplements you have taken in the last five years:

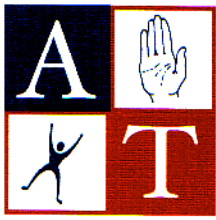
Please list all specialist doctors you have seen and approximate dates:

Are you seeing any doctors or health care professionals now for any reason? _____

Please list any practitioners you are currently seeing:

What other therapies are you using?

acupuncture chiropractic homeopathy massage
 magnets colonics nutritional supplements
 psychotherapy other (please specify) _____



SYMPTOM SURVEY

Number the boxes which apply to you.
 1 MILD (occurs once or twice a year)
 2 MODERATE (occurs several times a year)
 3 SEVERE (you are aware of it almost constantly)

Sympathetic Dominance

<input type="checkbox"/> acid foods upset	<input type="checkbox"/> gag easily	<input type="checkbox"/> appetite reduces
<input type="checkbox"/> get chilled often	<input type="checkbox"/> unable to relax	<input type="checkbox"/> cold sweats often
<input type="checkbox"/> "lump" in throat	<input type="checkbox"/> extremities cold, clammy	<input type="checkbox"/> fever easily raised
<input type="checkbox"/> dry mouth/eyes/nose	<input type="checkbox"/> strong light irritates	<input type="checkbox"/> neuralgia-like pains
<input type="checkbox"/> pulse speeds after meal	<input type="checkbox"/> urine amount reduced	<input type="checkbox"/> staring, blinks little
<input type="checkbox"/> keyed up, fail to calm	<input type="checkbox"/> heart pounds after lying down	<input type="checkbox"/> sour stomach frequent
<input type="checkbox"/> cuts heal slowly	<input type="checkbox"/> nervous stomach	

Parasympathetic Dominance

<input type="checkbox"/> joint stiffness after arising	<input type="checkbox"/> always seem hungry	<input type="checkbox"/> difficulty swallowing
<input type="checkbox"/> muscle/leg/toe cramps at night	<input type="checkbox"/> digestion rapid	<input type="checkbox"/> constipation/diarrhea
<input type="checkbox"/> "butterfly" stomach, cramps	<input type="checkbox"/> vomiting frequent	<input type="checkbox"/> "slow starter"
<input type="checkbox"/> eyes or nose watery	<input type="checkbox"/> hoarseness frequent	<input type="checkbox"/> get chilled infrequently
<input type="checkbox"/> eyes blink often	<input type="checkbox"/> breathing irregular	<input type="checkbox"/> circulation poor
<input type="checkbox"/> indigestion soon after meals	<input type="checkbox"/> gagging reflex slow	<input type="checkbox"/> common colds, bronchitis

Sugar Handling

<input type="checkbox"/> eat when nervous	<input type="checkbox"/> heart palpates if meals missed	<input type="checkbox"/> crave candy or coffee
<input type="checkbox"/> excessive appetite	<input type="checkbox"/> afternoon headaches	<input type="checkbox"/> moods of depression
<input type="checkbox"/> hungry between meals	<input type="checkbox"/> overeating sweets upsets	<input type="checkbox"/> abnormal craving snack
<input type="checkbox"/> irritable before meals	<input type="checkbox"/> light headed if meals delayed	<input type="checkbox"/> fatigue, eating relieve
<input type="checkbox"/> awoken after a few hours sleep, hard to get back to sleep		

Cardiovascular

<input type="checkbox"/> hands and feet numb	<input type="checkbox"/> drowsy often	<input type="checkbox"/> bruise easily
<input type="checkbox"/> sigh frequently	<input type="checkbox"/> swollen ankles	<input type="checkbox"/> tendency to anemia
<input type="checkbox"/> breathing heavily	<input type="checkbox"/> muscle cramps	<input type="checkbox"/> nose bleeds
<input type="checkbox"/> high altitude discomfort	<input type="checkbox"/> shortness of breath	<input type="checkbox"/> ringing in ears
<input type="checkbox"/> susceptible to colds/fevers	<input type="checkbox"/> afternoon "yawner"	
<input type="checkbox"/> dull pain in chest radiating into left arm worse on exertion		
<input type="checkbox"/> tension under the breastbone, feeling of tightness, worse on exertion		

Biliary and Liver

<input type="checkbox"/> dizziness	<input type="checkbox"/> worrier	<input type="checkbox"/> sneezing attacks
<input type="checkbox"/> dry skin	<input type="checkbox"/> queasy, headache over eyes	<input type="checkbox"/> bad dreams
<input type="checkbox"/> burning feet	<input type="checkbox"/> greasy foods upset	<input type="checkbox"/> bad breath
<input type="checkbox"/> blurred vision	<input type="checkbox"/> stools light-colored	<input type="checkbox"/> dairy causes distress
<input type="checkbox"/> itching skin and feet	<input type="checkbox"/> skin peels on feet	<input type="checkbox"/> sensitive to hot weather
<input type="checkbox"/> excessive hair falling out	<input type="checkbox"/> pain between shoulder blades	<input type="checkbox"/> burning or itching anus
<input type="checkbox"/> frequent skin rashes	<input type="checkbox"/> use laxatives	<input type="checkbox"/> crave sweets
<input type="checkbox"/> metallic taste in mouth	<input type="checkbox"/> stools alternate soft/watery	<input type="checkbox"/> difficult bowel movements
<input type="checkbox"/> history of gallbladder attacks or stones		



[athen s t h e r a p e u t i c s]

physical therapy & wellness center

Digestive

- | | | |
|--|--|--|
| <input type="checkbox"/> loss of taste for meat | <input type="checkbox"/> coated tongue | <input type="checkbox"/> irritable bowel |
| <input type="checkbox"/> lower bowl gas several hours after eating | <input type="checkbox"/> large amount of foul smelling gas | |
| <input type="checkbox"/> gas shortly after eating | <input type="checkbox"/> stomach bloating after eating | |
| <input type="checkbox"/> burning stomach sensations, eating relieves | <input type="checkbox"/> indigestion _ hr after eating | |

Endocrine

HYPERTHYROID

- insomnia
- nervousness
- can't gain weight
- intolerance to heat
- highly emotional
- flush easily
- night sweats
- thin, moist skin
- inward trembling
- heart palpitates
- Increased appetite
- pulse fast at rest
- eyelids and face twitch
- irritable and restless
- can't work under pressure

HYPERPITUITARY

- failing memory
- low blood pressure
- increased sex drive
- headaches "splitting"
- decreased sugar tolerance

HYPOPITUITARY

- abnormal thirst
- bloating of abdomen
- weight gain hips/waist
- sex drive reduced
- tendency to ulcers, colitis
- increased sugar tolerance
- menstrual disorders

HYPERADRENAL

- dizziness
- hot flashes
- headaches
- increased blood pressure
- hair growth on face/body
- sugar in urine
- masculine tendencies

HYPOADRENAL

- weakness/dizziness
- chronic fatigue
- low blood pressure
- nails weak ridged
- tendency to hives
- arthritic tendencies
- perspiration increase
- bowel disorders
- poor circulation
- swollen ankles
- crave salt
- brown spots/bronzing
- allergies/asthma
- weakness after cold/flu
- exhaustion muscular & nervous
- respiratory disorders

HYPOTHYROID

- | | |
|---|---|
| <input type="checkbox"/> increase in weight | <input type="checkbox"/> mental sluggishness |
| <input type="checkbox"/> decrease in appetite | <input type="checkbox"/> hair coarse, falls out |
| <input type="checkbox"/> fatigue easily | <input type="checkbox"/> headaches upon rising |
| <input type="checkbox"/> ringing in ears | (wears off during day) |
| <input type="checkbox"/> sleepy during day | <input type="checkbox"/> frequent urination |
| <input type="checkbox"/> sensitive to cold | <input type="checkbox"/> impaired hearing |
| <input type="checkbox"/> dry or scaly skin | <input type="checkbox"/> reduced initiative |
| <input type="checkbox"/> constipation | <input type="checkbox"/> slow pulse |

Female Only

- very easily fatigued
- premenstrual tension
- painful menses
- depressed feelings before menstruation
- menstruation excessive and prolonged
- painful breasts
- menstruate too frequently
- vaginal discharge
- menopausal hot flashes
- menses scantily or missed
- acne worse at menses
- depression of long standing

Male Only

- prostate trouble
- urination difficult or dribbling
- night urination frequent
- depression
- pain on inside of legs or heels
- feeling of incomplete bowel evacuation
- lack of energy
- migrating aches and pains
- avoids activity
- leg nervousness at night
- diminished sex drive