

PATIENT INFORMATION

<p>General Information</p> <p>Name _____</p> <p>Phone _____</p> <p>Address _____</p> <p>City _____ State _____ Zip _____</p> <p>Email Address _____</p> <p>Referred by: _____</p> <p>In case of emergency: _____</p> <p>Phone _____</p> <p>Date of Birth _____ Female <input type="checkbox"/> Male <input type="checkbox"/></p> <p>Occupation _____ Physician _____</p> <p>Insurance Information Out of Network <input type="checkbox"/></p> <p>Company: _____</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 30%;">Injuries/Surgeries</th> <th style="width: 40%;">Description</th> <th style="width: 30%;">Date</th> </tr> </thead> <tbody> <tr> <td>Falls</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Head Injuries</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Broken Bones</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Dislocations</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Surgeries</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table> <p>Are you pregnant? <input type="checkbox"/> NO <input type="checkbox"/> YES Due Date _____</p> <table border="1" style="width: 100%; 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font-weight: bold;">SHOULDERS</p> <table style="width: 100%; font-size: x-small;"> <tr> <td></td> <td style="text-align: center;">Right</td> <td style="text-align: center;">Left</td> </tr> <tr> <td><input type="checkbox"/> Pain in shoulder joint</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Pain across shoulder</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Can't raise arm</td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;"><input type="checkbox"/> Above shoulder level</td> <td></td> <td></td> </tr> <tr> <td style="padding-left: 20px;"><input type="checkbox"/> Over Head</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Tension in shoulders</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Pinched nerve in shoulder</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table> <p style="text-align: center; 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Please Print **SUBJECTIVE COMPLAINTS**

This section describes specifically why you are here (what the prescription is for)

Explain WHEN and HOW it happened: _____

COMPLAINTS/SYMPTOMS: Come and go Came on gradually Came on suddenly

Symptoms have persisted for: Hour 1 day Days Weeks Months Years

Symptoms developed from: A work-related injury An auto accident An injury other than work or an auto accident

Have you been treated for this problem? No Yes

If yes, by Physician Doctor of chiropractic Physical Therapist Osteopath Other _____

What did they do and/or recommend? _____

Is this condition getting progressively worse? Yes No

Does it interfere with your Work Sleep Daily Routine Recreation

What medications are you presently taking? _____ For what condition? _____

_____ For what condition? _____

DURING THE TREATMENT In order to derive the greatest benefit from this work, a couple of suggestion may be helpful. First, if at any time during the treatment you notice yourself unconsciously holding your breath, simply release your breath. Exhaling releases tension, holding your breath retains tension. Second, for the same reason if your therapist is applying pressure or stretching a muscle, also release your breath and your muscle will relax more easily. Finally, if at any time during the treatment, anything feels uncomfortable, please tell your therapist so that he or she can adjust the technique to your particular needs.

AFTER THE TREATMENT Everyone has a slightly different experience. Take a few moments to feel the effects of the treatment and discuss them with your therapist.

I have read the above information and discussed it with the therapist. I understand that this work does not constitute medical treatment, but rather is an adjunct to health maintenance utilizing the techniques and principles of neuro-muscular therapy. I take responsibility for alerting my therapist to any physical conditions which would affect this work.

SIGNED _____

Date _____