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INTAKE FORM



Your Life in Motion

www.tri-motionrehab.com

PERSONAL INFORMATION: *(Please print clearly)*

Name: _____
Last First Middle Initial

Home Address: _____
Street City State Zip

Telephone: H: () C: () W: ()

Date of Birth: _____ Sex: M / F Occupation: _____

Marital Status: S M W D Spouse's Name: _____ Email: _____

Emergency Contact: _____ P: () Relationship: _____

MEDICAL INFORMATION:

Reason for being seen: _____

Primary Physician: _____ Phone: ()

Referring Physician: _____ Phone: ()

Who referred you to our clinic *(if other than your physician)*: _____

Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.

1. What is the primary complaint that brings you in for treatment today?

Secondary complaint?

As a result, I am now having difficulty with:

Are you currently experiencing pain as a result of these symptoms? Yes No

2. When and how did your symptom(s) begin? Date: _____

3. Have you ever received the following treatment for this condition?

	Yes	No	How Long?	Helpful?
Physical Therapy	_____	_____	_____	Yes No
Myofascial Release	_____	_____	_____	Yes No
Chiropractic	_____	_____	_____	Yes No
Other: _____	_____	_____	_____	Yes No

4. Past Medical History (include dates of occurrence)

Surgeries: _____

Accidents: _____

5. List ALL medications which you are currently taking (include supplements, herbal and homeopathic remedies). Please include reason for medication.

6. Please place an "M" in front of each item that you experience at least MONTHLY. Place a "W" in front of each item that you experience WEEKLY or more frequently.

MUSCULO-SKELETAL:

- _____ Headaches/migraines _____
- _____ Joint stiffness _____
- _____ Joint swelling _____
- _____ Spasms/cramps _____
- _____ Fractured bones _____
- _____ Strains/Sprains _____
- _____ Back/hip pain _____
- _____ Neck/shoulder pain _____
- _____ Arm/hand pain _____
- _____ Leg/foot pain _____
- _____ Jaw pain/TMJ _____
- _____ Tendonitis _____
- _____ Bursitis _____
- _____ Scoliosis _____
- _____ Arthritis _____
- _____ Osteoporosis _____

CIRCULATORY/RESPIRATORY:

- _____ Dizziness _____
- _____ Shortness of breath _____
- _____ Chest pain/tightness _____
- _____ Heart disease _____
- _____ Varicose Veins _____
- _____ Fainting _____
- _____ Cold feet/hands _____
- _____ Lymphedema _____
- _____ Excessive sweating _____
- _____ Sweaty palms _____
- _____ Blood clots _____
- _____ Allergies _____
- _____ Sinus condition _____
- _____ Asthma _____
- _____ Hi/Lo blood pressure _____
- _____ Diabetes _____

DIGESTIVE/URINARY:

- _____ Indigestion _____
- _____ Constipation _____
- _____ Diarrhea _____
- _____ Bowel irregularity _____
- _____ Liver Disease _____
- _____ Bloating/gas _____
- _____ Heartburn _____
- _____ Stomach cramps _____
- _____ Nausea/vomiting _____
- _____ Painful urination _____
- _____ Frequent urination _____
- _____ Urgent urination _____
- _____ Incomplete urination _____
- _____ Unable to hold urine _____
- _____ Kidney disease _____

REPRODUCTIVE:

- _____ Currently pregnant _____
- _____ Previous pregnancies _____
- _____ # pregnancies _____
- _____ # live births _____
- _____ # premature births _____
- _____ Periods _____
- _____ Irregular periods _____
- _____ Painful periods _____
- _____ PMS _____
- _____ Endometriosis _____
- _____ Menopause _____
- _____ Hot flashes _____
- _____ Breast lump/tender _____
- _____ Hysterectomy _____
- _____ Prostate condition _____
- _____ Impotence _____

NERVOUS SYSTEM:

- _____ Numbness/tingling _____
- _____ Twitching of face _____
- _____ Fatigue _____
- _____ Tired during day _____
- _____ Extreme fatigue _____
- _____ Chronic pain _____
- _____ Sleep Disorders _____
- _____ Epilepsy/Seizures _____

MISCELLANEOUS:

- _____ Loss of appetite _____
- _____ Coughing _____
- _____ Stuffy nose, congestion _____
- _____ Vertigo/earache _____
- _____ Sore throat _____
- _____ Forgetfulness _____
- _____ Confusion _____
- _____ Hearing impaired _____

