CAMBER PHYSICAL THERAPY
FUSION CHIROPRACTIC

HEALTH INTAKE FORM

Name _____ Preferred Name _____ Age _____ Weight _____ Height _____

What's the reason for today's visit? _____

Have you had similar symptoms in the past? ☐ Yes ☐ No When? _____

Briefly describe how your problem began. _____

Date of onset/injury ____/____/____ Date of surgery ____/____/____ Type of surgery _____

Occupation _____ Type of work_____ Current work status _____

Do you drive? ☐ Yes ☐ No Do you have any lifting restrictions? ☐ Yes ☐ No Hand dominance ☐ Right ☐ Left
Do you live alone? ☐ Yes ☐ No Do you have stairs where you live? ☐ Yes ☐ No

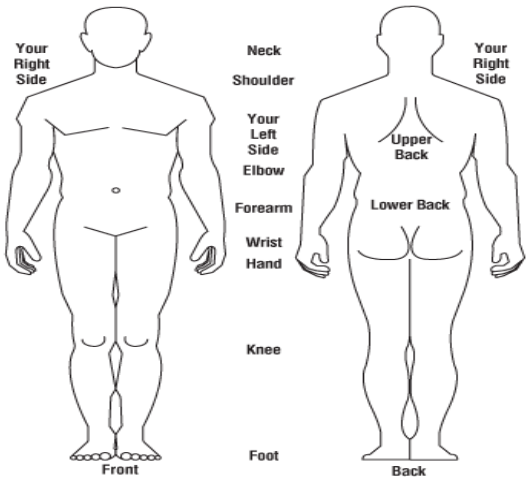
What goals would you like to achieve through therapy? ☐ Reduced pain ☐ Increased mobility ☐ Increased strength
Other specific goals include _____

Check any diagnostic tests received for this problem. Date tested ____/____/____ Body part tested _____
☐ Blood work ☐ Bone scan ☐ CT scan ☐ EMG ☐ MRI ☐ Ultrasound ☐ X-ray ☐ Other _____

If you have received or are currently receiving treatments for your current chief complaint, please check all that apply.

☐ Aquatic therapy ☐ Injections ☐ Pain management ☐ Surgical intervention
☐ Brace/Tape ☐ Massage ☐ Personal/Athletic training ☐ Other _____
☐ Chiropractic care ☐ Mechanical traction ☐ Physical therapy

Please mark diagram to show area of pain.



Please rate your pain. 0 is no pain. 10 is worst pain you can imagine.

Current level of pain _____
Worst level of pain in last three days _____
Best level of pain in last three days _____
Since it started, the pain is ☐ Worse ☐ Better ☐ Same

Where did your pain start? _____
My pain is ☐ Intermittent ☐ Constant ☐ Aching ☐ Shooting ☐ Sharp ☐ Cramping ☐ Other _____
☐ Throbbing ☐ Squeezing ☐ Dull ☐ Stabbing ☐ Sore ☐ Burning
What makes it worse? _____
What makes it better? _____
Does time of day affect pain? ☐ Yes ☐ No Does pain wake you from sleep? ☐ Yes ☐ No
Do you have tingling, numbness or loss of sensation? ☐ Yes ☐ No Weakness? ☐ Yes ☐ No Swelling? ☐ Yes ☐ No
If so, where? _____
Have you fallen two or more times in the past 12 months? ☐ Yes ☐ No Have you been injured as a result? ☐ Yes ☐ No

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HEALTH INTAKE FORM (page 2)

How would you rate your current health? ☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Please check the corresponding box to indicate if you have or have had any of the following conditions.

☐ Diabetes	☐ Alzheimer's Disease/Dementia	☐ Asthma
☐ Fibromyalgia	☐ Cerebral palsy	☐ Difficulty breathing
☐ Lupus	☐ Headaches/Migraines	☐ Shortness of breath
☐ Lyme disease	☐ Multiple sclerosis	☐ Emphysema
☐ Lymphedema	☐ Parkinson's disease	☐ A-Fib
☐ Obesity	☐ Seizures/Epilepsy	☐ Angina/Chest Pain
☐ Thyroid disorder	☐ Traumatic Brain Injury	☐ Cardiac Stents/Bypass
☐ Bleeding disorder	☐ TIA/CVA/Stroke	☐ COPD
☐ Hernia	☐ Psychiatric Disorder	☐ Heart disease
☐ Rheumatoid arthritis	☐ Anxiety/Depression	☐ Congestive heart failure
☐ Osteoarthritis	☐ Hepatitis	☐ High blood pressure
☐ Osteoporosis/Osteopenia	☐ HIV/AIDS	☐ Low blood pressure
☐ Scoliosis	☐ Acid Reflux/Ulcers	☐ High cholesterol
☐ Disc herniation	☐ Kidney Disease	☐ Cancer – Type _____
☐ Dislocation - Site _____	☐ Bowel/Bladder Dysfunction	☐ Other _____
☐ Fractures - Site _____	☐ Incontinence	☐ Other _____
☐ Currently pregnant # of weeks _____	☐ Hard of Hearing	☐ Other _____

Do you have or use the following?

☐ Glasses/Contacts	☐ Knee braces	☐ Crutches	☐ Pain pump	☐ Spinal stimulator
☐ Dentures	☐ Back braces	☐ Cane	☐ Insulin pump	☐ Grab bars
☐ Hearing aids	☐ Breast implants	☐ Walker	☐ Baclofen pump	☐ Ramp into home
☐ Shoe orthotics	☐ Metal implants	☐ Wheelchair	☐ Hydrocephalus shunt	☐ Stair glide
☐ AFO/Ankle braces	☐ Pacemaker	☐ Scooter/Rollator	☐ Deep brain stimulator	☐ Other

List all previous surgeries and dates for the last 5 years.

_____ _____ _____

_____ _____ _____

List (or provide list of) all current medications/supplements, dosage, and frequency. Write on back, if needed.

_____ _____ _____

_____ _____ _____

List all allergies that you may have. _____

Are there any beliefs, values, rules, or customs that the therapist needs to consider when treating you?

_____

To the best of my ability, I have given and included all pertinent medical information.

Patient/Guardian signature _____ Date_____

Patient name printed _____