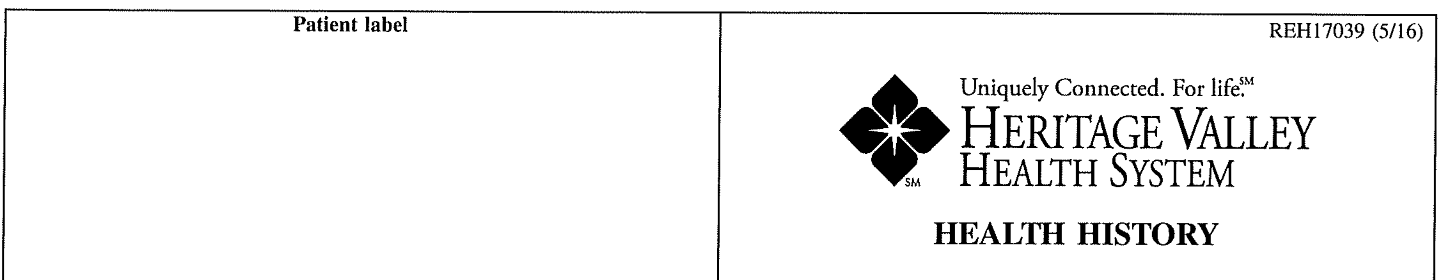
NAME	DATE OF BIRTH	PHONE
ADDRESS	EMAIL	
ORDERING DOCTOR	PRIMARY DOCTOR	
INSURANCE CO	POLICY HOLDER	

Please CIRCLE your answers:

1. Is this a new, recurring or chronic condition?
NEW RECURRING CHRONIC
2. What type of injury or condition is this?
PRE SURGICAL POST SURGICAL WORK COMP AUTO
3. How long have you had this injury/condition?
LESS THAN 1 MONTH 1 - 3 MONTHS MORE THAN 3 MONTHS

4. How many visits have you had with Physical or Occupational therapy this calendar year? ______
5. How many Chiropractic visits have you had this calendar year? __________

6. Do you moderately exercise 3 times per week? (when feeling well)	YES	NO
7. Do you feel confident that you will overcome this condition?	YES	NO
8. Are you presenting today because of a fall?	YES	NO
9. Have you experienced 2 or more falls within the last 12 months?	YES	NO
10. Do you have difficulty with your walking or balance?	YES	NO
11. Do you use any assistive walking devices? (cane, crutches, wheelchair, walker)	YES	NO



CHRONIC LUNG DISEASE	YES	NO	ANXIETY	YES	NO
CANCER If yes, type ____________	YES	NO	OBESITY	YES	NO
CARDIOVASCULAR DISEASE	YES	NO	TOBACCO USE	YES	NO
STROKE	YES	NO	ALCOHOL USE	YES	NO
NEUROLOGICAL CONDITION If yes, type ____________	YES	NO	CHRONIC PAIN (greater than 3 months)	YES	NO
DIABETES	YES	NO	PACEMAKER	YES	NO
DEPRESSION	YES	NO	DEFIBRILATOR	YES	NO

SURGERIES and/or additional MEDICAL PROBLEMS (with approximate date)

MEDICATIONS (prescription and over the counter)

ALLERGIES (drugs, anesthesia, food, blood, soap, dyes, environment)

LATEX SENSITIVITY Have you experienced the following symptoms (abdominal cramps, itching or peeling skin, throat congestion, runny nose, red swollen eyes, swollen lips, difficulty breathing) after:

Handling rubber products such as elastic bandages, baby bottle nipples, erasers, rubber gloves, rubber grips on handle bars, rubber bands, shoes	YES	NO
Blowing up balloons	YES	NO
Eating bananas, avocados, tropical fruits (kiwi, papaya)	YES	NO

NUTRITIONAL SCREENING

Changes in body weight Please circle: Gain/Loss # lb amount ________	YES	NO
Diet Restrictions Type of Diet ____________________	YES	NO
Recent Appetite	Good	Poor

SOCIAL

Have you been abused physically, emotionally, or sexually? For assistance call Case Management at 724-773-4800	YES	NO

PATIENTS SIGNATURE: ______________________ DATE __________ TIME __________

THERAPISTS SIGNATURE: ______________________ DATE __________ TIME __________