Name: _____ **Date:** _____

Preferred Pronouns: ◯he/him/his ◯she/her/hers ◯ they/them/their ◯ other_____

Who referred you to therapy? _____

Have you had any surgeries? ◯ No ◯ Yes If yes, date: _____

If yes, type: _____

Do you have any allergies? ◯ No ◯ Yes If yes, list allergies: _____

Past Medical History: Have you ever had any of the following conditions? Check all that apply.

◯ High blood pressure ◯ Heart condition ◯ Stroke ◯ Osteoporosis

◯ Peripheral Neuropathy ◯ Seizures/epilepsy ◯ Vision problems ◯ Diabetes

◯ Hearing problems ◯ Fainting/dizziness ◯ Emphysema ◯ Cancer

◯ Bowel/bladder problems ◯ Frequent or severe headaches ◯ Arthritis ◯ Asthma

◯ TBI/Concussion ◯ Brain injury ◯ Spinal Cord Injury ◯ Depression

◯ Anxiety ◯ Panic disorders

Other:_____

Is there any other information regarding your medical history that we should know about?

_____

Reason for visit? _____

_____

Do you take any medication? Please list (you may use reverse side): _____

_____

_____

Would you like a chaplain to contact you for emotional or spiritual support? ◯ No ◯ Yes

Signature of Patient or Guardian (if patient is a minor): _____**Date:** _____

Signature of Patient Representative: _____ **Date:** _____

Signature of Clinician: _____ **Date:** _____

If you are experiencing pain related to your reason for visit, please fill out the next page.

To help us understand your symptoms, please CIRCLE all that apply.

My pain is worse: in the morning/during the day/at night/constant/with activity/during rest/intermittent

My pain is better: in the morning/during the day/at night/with activity/during rest/intermittent

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best: _____ and at its worst: _____ In the past 7 days: _____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition

Key

↑ or ↓ Radiating Pain

XXX Spasm

ZZZ Tenderness

//// Numbness/Tingling

000 Ache/Pain