Case History Intake Form

Name:_____ Date: _____

Date of Birth:_____ Telephone: _____

Address:_____

Email Address:

How did you hear about us?_____ Occupation: _____

What are your goals for today's treatment? _____

Health History:

Have you had a manual osteopathic treatment before?_ Yes__ No

If yes, for what? _____

Are you currently being treated by a Chiropractor or Physical Therapist? Yes No

Any injuries within the past 72 hours?_ Yes__ No Explain _____

Past Surgeries_____ Date _____

Medications/Supplements/Drugs _____

Allergies _____

Please indicate Current conditions with a **C** and Previous with a **P**:

Respiratory:

___ Chronic cough

___ Shortness of breath
___ Bronchitis/Asthmas
___ Sinus infections
___ Emphysema
___ Smoke/Vape

Cardiovascular:

___ Cold hand/feet
___ High/low blood pressure
___ CCHF or Heart Attack
___ Varicose veins or phlebitis
___ Poor healing of wounds
___ Stroke/CVA
___ Pacemaker or other devices
___ Swelling in hands/feet

Skin:

___ Bruise easily

___Rash/open sore/warts
___Sensitivities/allergies: _____
___Contagious skin disease

Digestive:

___ Constipation
___ Nausea/vomiting
___ Ulcers/blood in stool
___Liver/kidney problems
___ Quick weight lose/gain
___Appetite changes
___ Ulcerated colitis/Crohn's/IBS

Infections:

___ Hepatitis
___ Tuberculosis
___ HIV

Head and Neck:
___ Tension/migraine headaches
___ Tinnitus (ringing in ears)
___ Tooth/jaw/ear pain
___ Vision problems/loss

___ Hearing loss
___ Dizziness/lightheaded
___ Other:_____

Soft tissue/Joint/Nerve:
___ Fibromyalgia
___ Arthritis__RA__OA
___ Herniated disc(s) Level____
___ Osteoporosis
___ Fracture (where:_____)
___ Thoracic Outlet Syndrome
___ Head trauma/concussion
___ Whiplash/car accident
___ Neck pain/stiffness/injury/numbness
___ Shoulder pain/stiffness/injury
___ Arm pain/weakness/tingling
___ Back pain/stiffness/injury
___ Leg pain/weakness/injury
___ Knee or foot pain/injury
___ Tendonitis/Tenosynovitis
___ Bursitis or dislocations

___Sport/work related injury
___Carpel tunnel syndrome

Women:

___Pregnant (due:_____)
___ Painful menstruation
___Hysterectomy
___ Birth control
C-section

Other Conditions:
___Loss of sensation
___Diabetes (onset/type:_____)
___Epilepsy
___Insomnia
___Depression/Anxiety
___ Multiple Sclerosis
___ Cancer (onset/type: _____)
___Other: _____

Other Questions:
___I get a good night sleep
___I eat a well-balanced diet
___I have low energy
___I feel good about life

Additional information: _____

Current Condition:
Please describe your current pain _____

_____

How long have you had this pain? _____

How did it start: _____

What aggravates it: _____

What relieves it: _____

Signature:_____

Date:_____

Therapist:_____

Date: _____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated: