Integrated Therapy, LLC
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Last Name: _____ First Name: _____ Date of Birth: _____

Referring Physician: _____ / Self Referred ☐ Date of Injury / Symptom Onset: _____

Height: _____ Weight: _____ Gender: ☐Female ☐Male

Allergies: _____

How did symptoms start? _____

Symptoms: ☐Constant ☐Intermittent ☐Only with activity ☐Getting better ☐Getting worse ☐Not changing

Describe how you feel now: _____

_____

Pain level now: None 0 - - - 5 - - - 10 Worst Numbness: ☐Yes ☐No

Have you had this injury / illness before? ☐Yes ☐No

Are you on disability? ☐Yes ☐No

Have you had any surgery? ☐Yes ☐No

List of current Medications: _____

Location of your symptoms: _____

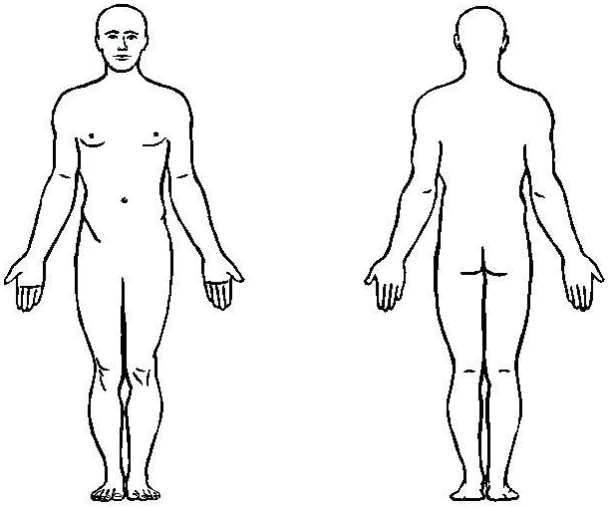
Occupation / Positions of stress: _____

Are you currently working? ☐Yes ☐No

How is your condition affecting your job? _____

If yes, are you under any restrictions from your doctor? ☐Yes ☐No

Do you exercise? ☐Yes ☐No



Draw Pain Pattern

Hobbies: _____

Falls? ☐Yes ☐No Car Accidents? ☐Yes ☐No Osteoporosis? ☐Yes ☐No

Past medical History: _____

Special tests / results : (X-ray, EMG, MRI, CT scan, blood tests, etc) _____

Unexplained weight change? ☐Yes ☐No Insomnia? ☐Yes ☐No

Do you smoke tobacco products? ☐Yes ☐No

List Assistive Devices (crutches, braces, shoe inserts, cane, walker): _____

Do you have metal implants? ☐Yes ☐No

Pacemaker? ☐Yes ☐No

Signature: _____ Print Name: _____ Date: _____