

# Patient Intake & History

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Personal History

Name: \_\_\_\_\_  
Last First Middle I.

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_, \_\_\_\_\_

Home Phone \_\_\_\_/\_\_\_\_/\_\_\_\_ Cell \_\_\_\_/\_\_\_\_/\_\_\_\_

Work Phone \_\_\_\_/\_\_\_\_/\_\_\_\_ May we contact you at work? Y N

Email Address \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN# \_\_\_\_ - \_\_\_\_ - \_\_\_\_ (Insurance cases only)

Sex: M F Marital Status (Circle) S M W D

Emergency Contact \_\_\_\_\_  
Not living with you Relationship Phone

Who may we thank for referring you? \_\_\_\_\_

## MEDICAL HISTORY

Family Doctor \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_

Are you ALLERGIC to ANY MEDICATIONS (Please List) \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_  
\_\_\_\_\_

Are you on any type of cholesterol medication? Y N If yes, which one? \_\_\_\_\_

Do you bruise easily? Y N

## DIAGNOSTIC TESTING

What diagnostic test(s) have you had done within the last 1 year?

\_\_\_ Blood Test \_\_\_ MRI \_\_\_ CT Scan \_\_\_ X-Ray

If yes, what were the findings of the test?

Female:

Are you pregnant? Y N If yes, how long? \_\_\_ Months

Are you on birth control? Y N If yes, what type? \_\_\_\_\_

Circle YES or NO

ARE YOU TAKING ANY MEDICINE FOR HIGH BLOOD PRESSURE?	YES	NO
HAVE YOU EVER HAD PHLEBITIS (BLOOD CLOTS)?	YES	NO
HAVE YOU EVER TAKEN AN ANTI-COAGULANT (BLOOD THINNER)?	YES	NO
ARE YOU TAKING AN ANTI-COAGULANT NOW?	YES	NO
HAVE YOU EVER HAD PAIN IN YOUR LEGS AFTER EXERCISING?	YES	NO
HAVE YOU EVER HAD CHEST PAIN AFTER EXERCISING?	YES	NO
DO YOU HAVE DIABETES?	YES	NO
TAKE INSULIN?	YES	NO
DO YOU HAVE PAIN OR BURNING WITH URINATION?	YES	NO
ARE YOU TIRED IN THE MORNING? (more than you think you should be)	YES	NO
HAVE YOU HAD ANY SUDDEN GAIN/LOSS IN WEIGHT?	YES	NO
DO YOU HAVE HEART PALPATATIONS?	YES	NO
DO YOU HAVE COLD HANDS/FEET?	YES	NO
DO YOU NOW, OR HAVE YOU EVER HAD CANCER?	YES	NO
HAVE YOU, OR A FAMILY MEMBER, BEEN DIAGNOSED WITH A THYROID PROBLEM?	YES	NO
HAVE YOU BEEN DIAGNOSED WITH FIBROMYALGIA?	YES	NO

#### OTHER

PLEASE LIST ANY OTHER DIAGNOSIS YOU HAVE RECEIVED:

PLEASE LIST ANY SURGERIES AND THE DATES PERFORMED:

## Vocational

Present Occupation \_\_\_\_\_

Do you spend time on the phone? Y N      If yes, how much time in a given day \_\_\_\_\_

Do you work on a computer? Y N      If yes, how long each day \_\_\_\_\_

Previous 2 Occupations if at your current one for less than 3 years

\_\_\_\_\_  
\_\_\_\_\_

Job Stress: High Medium Low

Hand Dominance: Right Left

Eye Dominance: Right Left

## Health/Nutritional

Do you drink any caffeinated beverages? Y N → \_\_\_ Coffee \_\_\_ Tea \_\_\_ Soda

How many ounces of each? \_\_\_ Coffee \_\_\_ Tea \_\_\_ Soda

Do you use DIET or sugar free products? Y N If yes, list about how many on a normal basis. \_\_\_\_\_

Do you crave any particular foods? Y N What foods? \_\_\_\_\_

Are there any foods you avoid? Y N What foods? \_\_\_\_\_

Do you eat out? Y N How many times per week? \_\_\_\_\_

Do you drink? Y N What do you usually drink? \_\_\_\_\_ How often? \_\_\_\_\_

Do you smoke? Y N How many packs per day? \_\_\_\_\_

Do you take any herbal or nutritional supplements? Y N

If yes, please list: \_\_\_\_\_

## Sports/Hobbies ( ) Not applicable

Do you currently play any sports or have any hobbies? Y N

If yes, what sports or hobbies? \_\_\_\_\_

How many times per week? \_\_\_\_\_

Have you had to quit any sports or hobbies because of pain/dysfunction? Y N

If yes, what sports or hobbies? \_\_\_\_\_

How long ago? \_\_\_\_\_

Exercise/Weight Training ( ) Not applicable

Do you currently have an exercise routine (even if not consistent)? Y N

Do you engage in isometric exercises? Y N

If female, are you training at Curves? Y N

Do you use a treadmill? Y N

If yes, is it level or inclined? \_\_\_\_\_

Do you use free-weights? Y N

If yes, please check all that apply:

\_\_ Bench Press → \_\_ level \_\_ incline \_\_ decline

\_\_ Dumbbell Press → \_\_ level \_\_ incline \_\_ decline

\_\_ Seated Front/Rear Barbell Press

\_\_ Cable Side Raises

\_\_ Lat Machine \_\_ Barbell/Dumbbell Wrist Curls

\_\_ Dead Lift \_\_ Leg Press

\_\_ Abdominal Exercises → If yes, which ones? \_\_\_\_\_

Other:

## Pain

Please describe the event that you believe caused your pain and how long ago it occurred.

Please describe where you feel your pain.

Please describe the sensation of pain  
(Deep, dull, and aching / sharp and lancinating / burning and irritating). ←- Circle One Section

Pain Onset - 1. Suddenly or 2. Gradually, then became worse ←- Circle One

What makes your pain better?

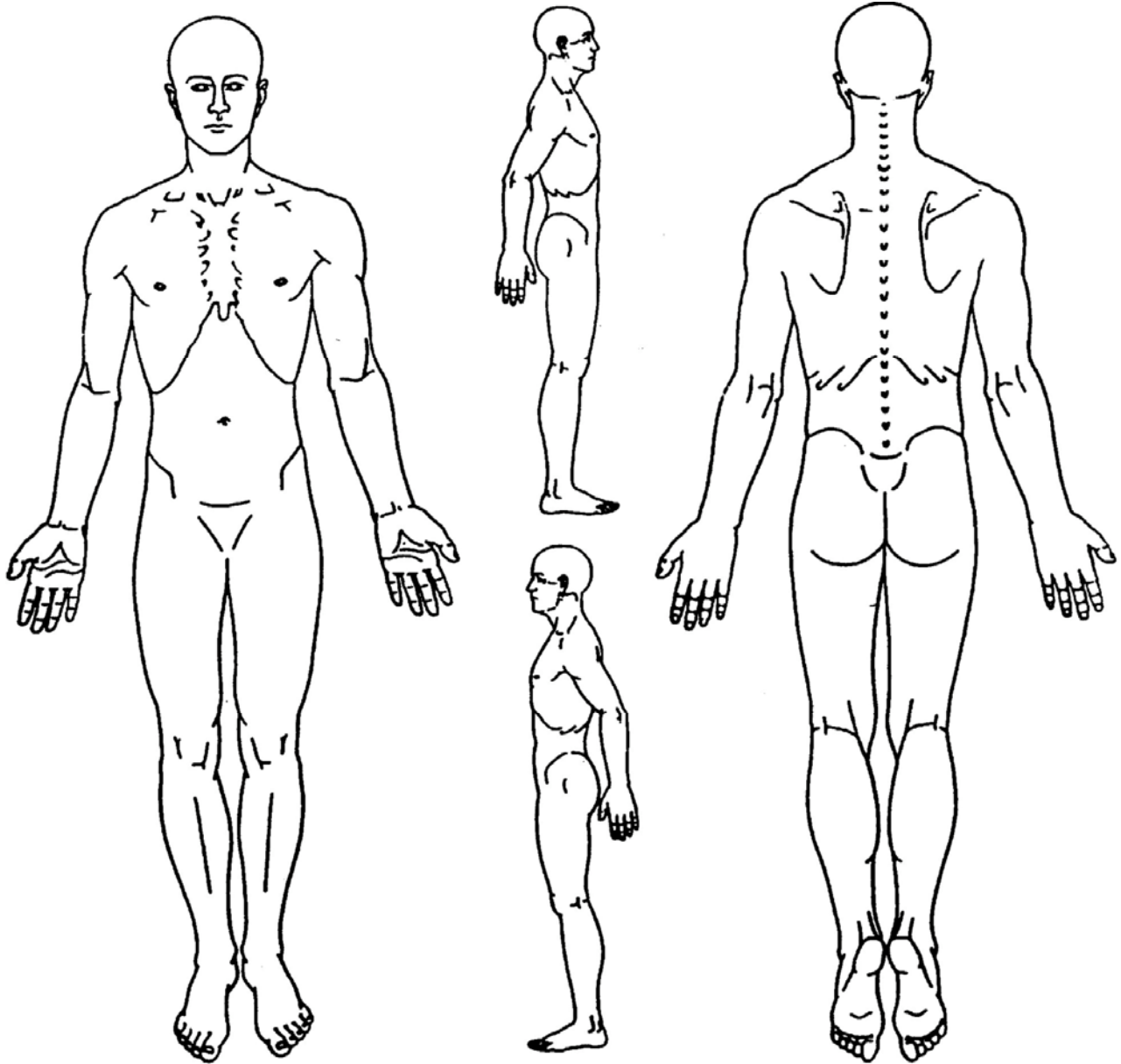
What makes your pain worse?

**\*\*Do you have any other symptoms which concern you, even if unrelated to pain?\*\*\***

## Pain Map

At this time, where is your pain?

Mark the body diagram where your pain is by circling or marking X's where the pain is.



**Pain Scales** - Place a slash between the two marks that indicates the amount of pain you are experiencing. The area to the very left is the LEAST pain and the area to the right is the MOST pain.

Pain you feel right now.

|-----|  
LEAST PAIN MOST PAIN

Pain when it is at its worst.

|-----|  
LEAST PAIN MOST PAIN

Pain when at its best (least amount of pain you experience with your condition).

|-----|  
LEAST PAIN MOST PAIN

### Sleep

How many hours of sleep do you average per night? \_\_\_\_\_

Do you sleep straight through? Y N

If no, why do you wake up? \_\_\_\_\_

Do you snore? Y N

Has anyone ever told you that you stop breathing while you sleep? Y N

Are you tired during the day? Y N

Do you use a pillow? Y N How many? \_\_\_\_\_

How old is your mattress? \_\_\_\_\_ yrs. Does your bed sag anywhere? Y N

Healthcare Providers and Correspondence

Please list ALL the healthcare providers you are seeing or have seen for the condition for which you are presenting to this office for treatment. Please include medical doctors, chiropractors, physical therapists, massage therapists, acupuncturists, etc.

Upon your request, we will furnish your health care provider(s) a copy of your treatment notes from this practice. We recommend this especially for those chronic pain patients who try many different therapies and have several doctors, a chiropractor, PT, etc. so we may all work better as a team as well as to provide information about your treatments and outcomes.

1. Provider name: \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_



Sign here if you would like your treatment notes sent to this provider.  
\_\_\_\_\_  
Signature

2. Provider name: \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_



Sign here if you would like your treatment notes sent to this provider.  
\_\_\_\_\_  
Signature

3. Provider name: \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_



Sign here if you would like your treatment notes sent to this provider.  
\_\_\_\_\_  
Signature

**\*\* If there are other providers, please list them on the back of this page.**

**CONSENT FOR SERVICES**

PATIENT \_\_\_\_\_ (Please print)

I, the undersigned, hereby voluntarily consent to treatments to be performed by Jeffrey A. Lutz, CMTPT. I acknowledge that no guarantees have been made to me as to the result of treatments.

X

Date

