Compassionate Therapies
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www.CompassionateTherapies.com
425-422-8455

Patient Information

Name: _____
Address _____
City _____ State _____ Zip _____
Phone: Home _____
Work _____ Cell _____
Date of Birth _____
Employer _____
Occupation _____
Insurance ID#: _____
Emergency Contact _____
Phone: Home _____
Work _____ Cell _____

Current Health Information

List health concern(s). Check all that apply.

- Primary _____

Severity? ☐ Mild ☐ Moderate ☐ Disabling
Duration? ☐ Constant ☐ Intermittent
Do symptoms change with activity?
☐ Symptoms increase ☐ Symptoms decrease
Are symptoms?
☐ Getting worse ☐ Getting better ☐ No change
Treatment received _____

- Secondary _____

Severity? ☐ Mild ☐ Moderate ☐ Disabling
Duration? ☐ Constant ☐ Intermittent
Do symptoms change with activity?
☐ Symptoms increase ☐ Symptoms decrease
Are symptoms?
☐ Getting worse ☐ Getting better ☐ No change
Treatment received _____

- Additional _____

Severity? ☐ Mild ☐ Moderate ☐ Disabling
Duration? ☐ Constant ☐ Intermittent
Do symptoms change with activity?
☐ Symptoms increase ☐ Symptoms decrease
Are symptoms?
☐ Getting worse ☐ Getting better ☐ No change
Treatment received _____

- List all conditions currently monitored by a Health Care Provider _____

_____
_____

Primary Health Care Provider

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Fax _____
I give my manual therapist permission to consult with my referring health care provider regarding my health and treatment.
Comments _____
Initials _____ Date _____

Health History

List and Explain. Include dates and treatment.
Surgeries _____
_____
Accidents _____
_____
Major Illnesses _____
_____
List the medications you took today (include pain relievers and herbal remedies) _____
_____
List all other medications taken in the last three months _____
_____
Have you ever received Manual Therapy before?
☐ Yes ☐ No Frequency? _____

List Daily Activities

Work _____
_____
Home/Family _____
_____
Social/Recreational _____
_____
Circle the activities affected by your condition, or check here ☐ to indicate all of the above.
Check other activities affected:
☐ Sleeping ☐ Washing ☐ Dressing ☐ Fitness
How do you reduce stress? _____
_____
Pain? _____
_____
What are your goals for receiving Manual Therapy? _____
_____

Please check all current and past conditions. Please explain.

General

Current	Past	
☐	☐	Headaches
☐	☐	Pain
☐	☐	Sleep disturbances
☐	☐	Fatigue
☐	☐	Infectious
☐	☐	Fever
☐	☐	Sinus
☐	☐	Other_____

Skin Conditions

☐	☐	Rashes
☐	☐	Athlete's foot, Warts
☐	☐	Other_____

Allergies

☐	☐	Scents, Oils, Lotions
☐	☐	Detergents
☐	☐	Other_____

Nervous System

☐	☐	Head injuries, Concussions
☐	☐	Dizziness, Ringing in the ears
☐	☐	Loss of memory, Confusion
☐	☐	Numbness, Tingling
☐	☐	Sciatica, Shooting pain
☐	☐	Chronic pain
☐	☐	Depression
☐	☐	Other_____

Digestive/Elimination System

Current	Past	
☐	☐	Bowel dysfunction
☐	☐	Gas, bloating
☐	☐	Bladder or Kidney dysfunction
☐	☐	Abdominal pain
☐	☐	Other_____

Muscles and Joints

☐	☐	Rheumatoid arthritis
☐	☐	Osteoarthritis
☐	☐	Osteoporosis
☐	☐	Scoliosis
☐	☐	Broken bones
☐	☐	Spinal problems
☐	☐	Disk problems
☐	☐	Lupus
☐	☐	TMJ, Jaw pain
☐	☐	Spasms, Cramps
☐	☐	Sprains, Strains
☐	☐	Tendonitis, Bursitis
☐	☐	Stiff or painful joints
☐	☐	Weak or sore muscles
☐	☐	Neck, shoulder, arm pain
☐	☐	Back, hip, leg pain
☐	☐	Other_____

Endocrine System

☐	☐	thyroid dysfunction
☐	☐	Diabetes

Respiratory, Cardiovascular

Current	Past	
☐	☐	Heart disease
☐	☐	Blood clots
☐	☐	Stroke
☐	☐	Lymphedema
☐	☐	High or low blood pressure
☐	☐	Irregular heart beat
☐	☐	Poor circulation
☐	☐	Swollen ankles
☐	☐	Varicose veins
☐	☐	Chest pain, Shortness of breath
☐	☐	Asthma
☐	☐	Other?

Reproductive System

☐	☐	Pregnancy
☐	☐	Painful or emotional menses
☐	☐	Fibrotic cysts

Cancer/Tumors

☐	☐	Benign
☐	☐	Malignant

Habits

☐	☐	Alcohol
☐	☐	Drugs
☐	☐	Coffee, Soda

Contract for Care

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my manual therapist to provide safe and effective treatment.

Consent for Care

It is my choice to receive manual therapy, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health.

Signature _____ Date _____

Signature of parent or guardian _____ Date _____