FASCIAL STRETCH THERAPY INTAKE

TODAY'S DATE _____/_____/_____

NAME _____ MALE ___ FEMALE ___ BIRTHDATE _____/_____/_____ AGE_____

HOW YOU PREFER TO BE ADDRESSED _____ EMAIL ADDRESS _____

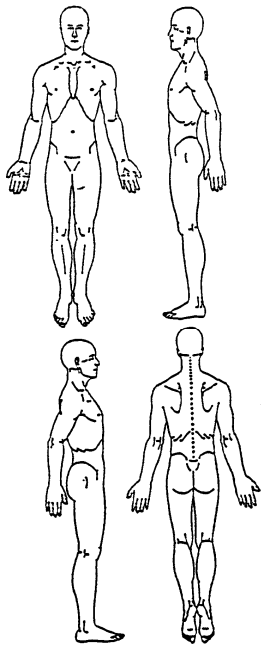
STREET ADDRESS _____ HOME PHONE _____-_____-_____

CITY _____ STATE _____ ZIP CODE _____ CELL PHONE _____-_____-____

EMPLOYER'S NAME _____ WHAT DO YOU DO THERE? _____

REFERRED TO OUR OFFICE BY _____

IN CASE OF EMERGENCY CONTACT_____ PHONE # ____-_____-_____ RELATIONSHIP _____



WHERE ARE YOUR SYMPTOMS LOCATED? MARK THE AREAS ON THE FIGURES TO THE LEFT.

WHAT IS YOUR MAIN REASON FOR COMING TO THERAPY? _____

WHAT SPECIFIC GOALS WOULD YOU LIKE TO ACHIEVE FROM THERAPY? _____

_____

HOW AND WHEN DID THE SYMPTOMS BEGIN? _____

HOW LONG HAVE YOU HAD THESE SYMPTOMS? _____

ARE YOU CURRENTLY, OR HAVE YOU BEEN UNDER MEDICAL SUPERVISION FOR THIS PROBLEM? _____

HAVE YOU HAD ANY TESTS FOR THIS PROBLEM? X-RAY MRI CT SCAN

ON A SCALE OF 1:10, WITH 10 BEING SEVERE DISCOMFORT, WHAT IS YOUR PAIN LEVEL? ___

DESCRIBE THE SYMPTOMS: PLEASE CIRCLE ALL THAT APPLY.

DULL ACHE BURNING SHARP PERIODIC CONSTANT SORE STIFF NUMB TINGLING

WHAT MAKES IT BETTER OR WORSE? _____

WHAT TIME OF DAY IS THE PAIN WORSE? MORNING MID-DAY EVENING NIGHT/SLEEPING

DO YOU HAVE TROUBLE SLEEPING? IF YES, WHAT POSITION DO YOU SLEEP IN? _____

CURRENT PHYSICAL ACTIVITIES: _____ DO YOU STRETCH? _____

BodyWise Chiropractic
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HAVE YOU EVER HAD CHIROPRACTIC TREATMENT? IF YES, HOW LONG, HOW OFTEN, AND WITH WHOM? _____

_____

DO YOU WEAR ANY TYPE OF SUPPORTIVE BRACES ANYWHERE? _____ DO YOU WEAR ORTHOTICS? _____

WHAT PERCENTAGE OF YOUR DAY IS SPENT SITTING? _____ STANDING? _____ DRIVING?_____

ARE YOUR SYMPTOMS WORSE AT THE END OF THE WORKDAY? _____ IS YOUR WORKSTATION ERGONOMIC? _____

HOW WOULD YOU RATE YOUR OWN POSTURE? _____

MEDICAL HISTORY

PLEASE LIST ANY RECENT INJURIES, ILLNESS, OR SURGERIES: _____

_____

ARE YOU CURRENTLY UNDER THE CARE OF A PHYSICIAN? _____ IF YES, PLEASE EXPLAIN: _____

LIST CURRENT MEDICATIONS, INCLUDING OVER THE COUNTER DRUGS LIKE IBUPROFEN: _____

_____

PLEASE CHECK ALL THAT APPLY:

___CANCER	___ HIGH/LOW BLOOD PRESSURE	___ EPILEPSY
___DIGESTION PROBLEMS	___ELIMINATION PROBLEMS	___ULCERS
___MIGRAINES/HEADACHE	___RESPIRATORY PROBLEMS	___COLD HANDS/FEET
___BACK PROBLEMS	___SINUS PROBLEMS	___HEART PROBLEMS
___SCIATICA	___NECK PROBLEMS	___BRUISE EASILY
___STROKE	___ARTHRITIS/BURSITIS	___ALLERGIES
___SCOLIOSIS	___IMMUNE DISORDER	___FIBROMYALGIA
___OSTEOPOROSIS	___TMJ	___CARPAL TUNNEL
___DIABETES	___TENDONITIS	___ASTHMA

DO YOU HAVE ANY CHRONIC OR FREQUENT PAIN? _____

HAVE YOU HAD ANY ACCIDENTS, AUTO OR OTHER? _____

HAVE YOU HAD ANY MAJOR SURGERIES? _____

HAVE YOU EVER HAD A HEAD INJURY? _____ DIZZINESS? _____ CHANGE IN HEARING? _____ CHANGE IN VISION? _____

ARE YOU CURRENTLY PREGNANT? _____ IF YES, HOW FAR ALONG? _____ # OF PREGNANCIES TO TERM: _____

ARE THERE ANY OTHER MEDICAL PROBLEMS WE SHOULD BE AWARE OF? _____

THE ABOVE INFORMATION IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE. IF THERE ARE ANY CHANGES IN MY CURRENT LEVEL OF HEALTH, I WILL INFORM THE DOCTOR IMMEDIATELY. I CONSENT TO TREATMENT PROVIDED BY DR. BOBBIE BENNETT. I AGREE TO PAY MY ACCOUNT WITH THIS OFFICE IN ACCORDANCE WITH THE REGULAR RATES AND PAYMENT TERMS. IF, FOR ANY REASON CANCELLATION IS NECESSARY, I WILL GIVE A 24- HOUR NOTICE. I UNDERSTAND THAT IF I DO NOT GIVE THIS NOTICE, I WILL BE CHARGED FOR THE APPOINTMENT UNLESS IT CAN BE FILLED.

_____ _____

SIGNATURE DATE

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