MANCHESTER-BEDFORD MYOSKELETAL LLC

Patient Health History

Handedness: R L Ambi Date: mm/dd/yyyy

Name: First, MI, Last Date of Birth: mm/dd/yyyy

Primary Care Physician: _____ _____ XXX-XXX-XXXX

(Name) *(Clinic/City)* *(Phone)*

Referred By: _____

If currently under a physician's care other than your primary, state doctor's name, clinic, & phone:

_____ XXX-XXX-XXXX

Reason for seeking treatment (complaint(s)): _____

_____

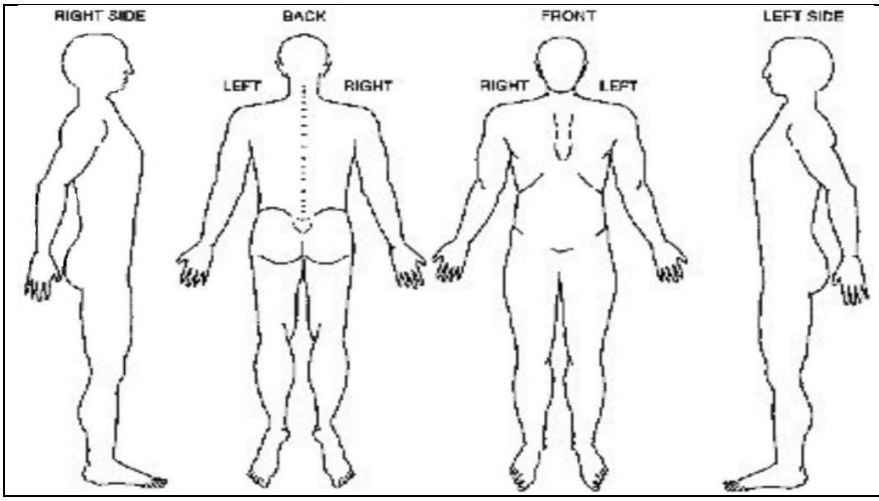
Previous intervention for this complaint: _____

Goals for treatment here: _____

Workplace Injury? Yes No Worker's Comp

If current problem resulted from a motor vehicle accident, please diagram below:

Please place letters from legend below as closely as possible to spots on diagram where you experience pain, injury, tension, stiffness, or restriction of movement:



M = Mild	O = Mod	E = Severe
D = Dull	S = Sharp	B = Stabbing
H = Hot	P = Pulsating	A = Aching
G=Shooting	T=Tingling	R=Throbbing
If pain travels, place an 'X' where it starts and draw an arrow to where it travels		
Please indicate location of any known scars by drawing a lightning bolt at the location		

Please check any of the following you have had or are now having problems with:

Anemia	Arches Flat High	Athlete's Foot	Blood Pressure High Low	Bowel/Bladder Problem	Bronchitis
Bursitis	Carpal Tunnel Syndrome	Chest Wall Pain	Constipation	Coronary Heart Disease	Diabetes
Dizziness/ Vertigo	Fibromyalgia/ Polymyalgia	Forward Head Posture	Headache (non-migraine)	Heart Condition	Hernia
Hepatitis A B C	Herpes Type 1 Type 2	Hip Pain/ Surgery (non-repl.)	Hip Replacement Left Right	Immune Deficiency	Jaw/TMJD
Knee Replacement Left Right	Kyphosis Hyper Hypo	Migraine	Nervousness	Osteoarthritis	Pacemaker
Palpitations	Phlebitis	Plantar Fasciitis Left Right	Poor Circulation	Pregnant/ Childbirth	Range of Motion Limited/Restricted
Rheumatoid Arthritis	Rib Dysfunction	Rotator Cuff Disorder (no surg)	Rounded Shoulders	Sacroiliac Joint Dysfunction/Pain	Seizure/ Convulsion
Sciatica/Piriformis Syndrome	Spinal Fusion Cer Th Lu	Spinal Rods	Spinal Stenosis	Spondylolisthesis	Thoracic Outlet Syndrome

Acute pain/injury: _____

Chronic (> 3 mos) pain/injury: _____

Recent surgeries (past 2 yrs): _____

Older surgeries: _____

Bone break/fracture (past 5 yrs): _____

Severe muscle strain/sprain/tear (past 5 yrs): _____

Other medical conditions: _____

Allergies: _____

Current medications (including naturopathic): _____

Do you wear eyeglasses or contacts? Yes No Reading

Regular exercise? (Per week frequency): None 1-2 3-5 Daily

Activities: _____

Please read carefully, print this document, and sign below.

I attest that the information I have provided is true and complete to the best of my knowledge. I understand that the information provided by me on this form is confidential and will not be released without my written consent.

Print Name: _____ Signature: _____