



Manual Medicine  
advanced therapeutics in healing

INTAKE INFORMATION

Name: \_\_\_\_\_ Current Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address:

\_\_\_\_\_ (street)

\_\_\_\_\_ (city) \_\_\_\_\_ (state) \_\_\_\_\_ (zip)

Phone: (home) \_\_\_\_\_ (work/cell) \_\_\_\_\_

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

**➤ Please complete the following information in detail. This will assist me in designing the most effective and efficient individualized program for you. Thank you for your effort.**

Who referred you? \_\_\_\_\_

Official Diagnosis/Reason for Visit:

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

Please list the main complaints/challenges you have in order of their importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Occupation:

\_\_\_\_\_

If you are currently not working due to pain/illness, how long have you not worked? \_\_\_\_\_

How many hours do you sleep at night? \_\_\_\_\_

How would you consider your present level of activity? \_\_\_\_poor \_\_\_\_fair \_\_\_\_good \_\_\_\_excellent

Please list activities you do:

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



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Are you seeing any doctors or health care professionals for any reason? (Note: These practitioners will not be contacted without your permission.)

Practitioner's Name	Type of Practitioner	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

➤ A goal list will help me recognize what you would like to accomplish. Goals will be revised as needed.

The following are examples provided to assist you in your answer.

**I know I will be better when I can:**

Example 1: Walk independently for 15 minutes with no pain.

Example 2: Work using just a splint for a half day with occasional pain.

Example 3: Sit at the computer without any pain for one hour.

Example 4: Play a game of tennis without pain in my back.

Please list five statements that finish the statement: **“I know I will be better when I can...”**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

List trauma/accidents (old and new) and when each occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

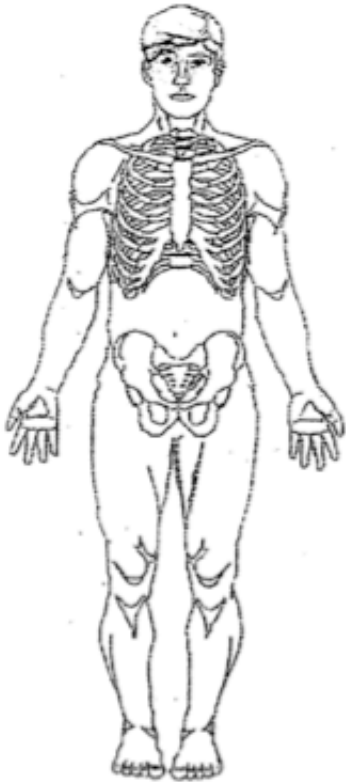
List any operations or hospitalizations: \_\_\_\_\_

\_\_\_\_\_

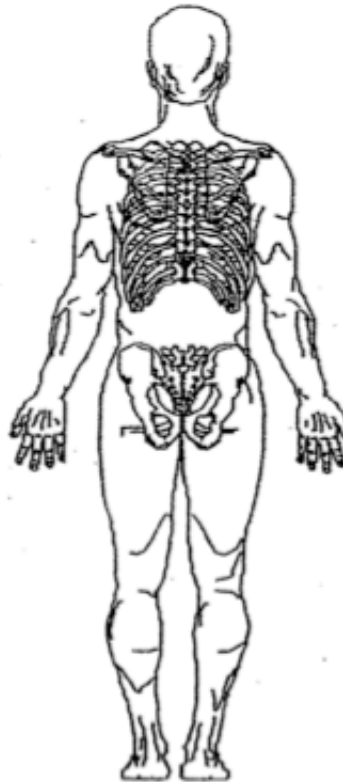


**Pain Diagram:** Please shade in all areas of pain. Be as thorough and specific as possible.

Front



Back



Right Side



Left Side

