NICS THERAPY CENTERS
PATIENT HISTORY FORM
Information you provide here is privileged and confidential. Your privacy will be respected.

Date: ____________________

First Name: ______________________ Middle Initial: _______ Last Name: _________________________

Address: ____

City/State/Zip: ____

Phones - Home: ___________________ Work: ________________________ Cell: __________________

Birthdate: _____/_____/__________ Sex: ______ Marital Status: _________ # of children ___________

Occupation: __________________________ Employer: ____

Work Site - City/State/Zip: ____

Name of Spouse or "Significant Other": ____

Their Employer: ______________________________________ Work Phone: ______________________

Work Site - City/State/Zip: ____

Who referred you to us? ____

****

Height: ________ Weight: __________ Age: _______ General health: ___________________________

Which of the following "Complementary" health care therapies have you utilized? (please circle)

Massage/Bodywork Chiropractic Nutritional Acupuncture Homeopathic Naturopathic

Other: ____

Describe the health care reason for which you came to see us: ___________________________________

____

When did this start and/or how did this develop? ____

Other Professionals seen for this problem: ____

Diagnosis, if known, and current treatment: ____

Describe the results from previous treatments for this condition: ________________________________

____

Activities/tasks/movements which you are unable to perform, or which cause or increase pain:

____

Work missed due to the presenting problem noted above: _______________________________________

List ALL surgeries (with year they occurred): ____

____ (cont. on back of page if necessary)

List ALL accidents, injuries, and falls (with the year they occurred): ______________________________

____ (cont. on back)

Are you currently under a physician's care? Yes No If yes, please explain: ________________________

____

Name: ____ **Date:** ______________________

Please list prescriptions used and their purpose: ____________________________________ (cont. on back)

Please list other medications/supplements: _____________________________________ (cont. on back)

Have you had any serious illnesses in the past 3 years? Yes No If yes, please explain:

____

Do you have any skin disorders or allergies? Please list: _______________________________________

____

Do you regularly drink caffeine beverages (coffee, tea, soda, etc.)? Yes No How much? _____________

Do you use tobacco? Yes No How many packs a day? _________

Do you drink alcoholic beverages? Yes No If yes, how much? ________________________________

Women: Are you pregnant? Yes No If yes, what is the estimated due date? ____________________

Have you been engaging in any physical-fitness-type activity on a regular basis? Yes No

Please describe: ____

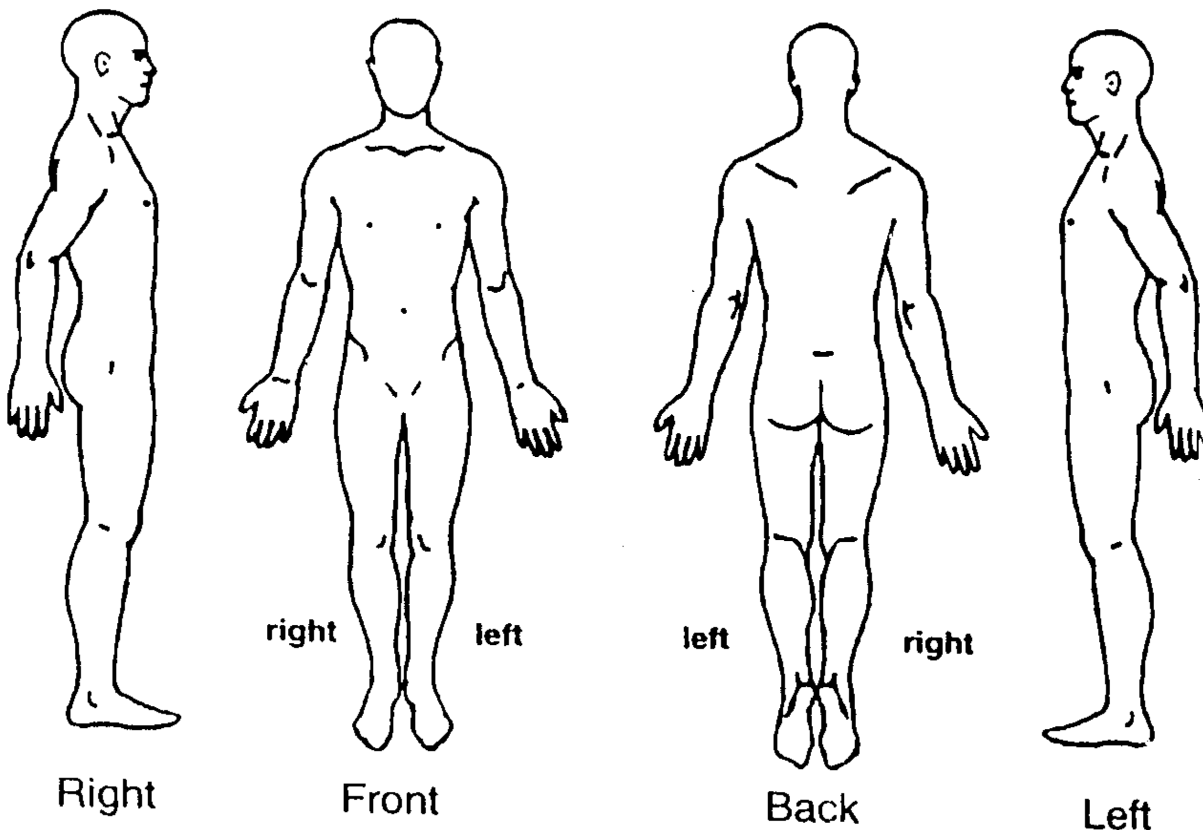
Do you have <u>ANY</u> <u>OTHER</u> medical condition or physical limitation that we as health care providers may need to be aware of before you receive treatment? Yes No If yes, please describe: _____________

____

Do you have any emotional issues relating to bodywork or touch? Yes Uncertain No

If yes or uncertain, please describe: ____

Please **<u>shade in</u>** clearly **<u>ALL areas</u>** where you have frequent or occasional pain:



Name: ______________________________ **Date:** ____________________

Please check all of the following that now apply or have applied to you:

System-wide Dysfunctions:
- ❑ Arthritis
- ❑ Broken bones
- ❑ Cancer
- ❑ Diabetes
- ❑ Edema (swelling)
- ❑ Fatigue
- ❑ Fibromyalgia Syndrome
- ❑ Joints inflamed
- ❑ Osteoporosis
- ❑ Sleep problems
- ❑ Tremors/'Shakes'

Allergies/Sensitivities:
- ❑ Medications
- ❑ Foods/additives
- ❑ Chemicals/fragrances

Back/Buttocks/Hips/Pelvis:
- ❑ Lower back pain
- ❑ Mid back pain
- ❑ Upper back pain
- ❑ Herniated or ruptured disks
- ❑ Hip pain
- ❑ Coccyx (tail-bone) pain

Balance/Ears/Eyes:
- ❑ Dizziness
- ❑ Falls/loss of balance
- ❑ 'Accident-prone'
- ❑ Ear-aches
- ❑ Ear infections - frequent
- ❑ Tubes in ears
- ❑ Ears 'ring', 'hum', etc.
- ❑ Hearing problems
- ❑ Hearing aid
- ❑ Eye pain
- ❑ Glasses or contacts
- ❑ Eye surgeries
- ❑ Other vision problems

Circulation/Blood/Veins:
- ❑ Anemia (low iron)
- ❑ Blood sugar -- High Low
- ❑ Blood clots
- ❑ Fainting
- ❑ Blood pressure -- High Low
- ❑ Heart surgeries
- ❑ Other Circulatory problems
- ❑ Varicose veins
- ❑ Vein Surgery
- ❑ Stroke

Chest/Breathing/Ribs:
- ❑ Asthma
- ❑ Chest pain
- ❑ Pain with a deep breath
- ❑ Shortness of breath

Emotional Issues:
- ❑ Anger/Hostility issues
- ❑ Dependency issues
- ❑ Significant depression
- ❑ Significant irritability
- ❑ 'Mood swings'
- ❑ Issues with being touched

Female concerns:
- ❑ Breast problems (any kind)
- ❑ Difficult pregnancies/births
- ❑ Fertility concerns
- ❑ PMS - significant problems
- ❑ Strong menstrual cramps

Head/Brain/Neck/Throat:
- ❑ Headaches
- ❑ Brain feels 'in a fog' - thinking Is 'fuzzy' or 'poorly connected'
- ❑ Neck pain
- ❑ 'Stiff neck' or restricted movement
- ❑ Sinusitis
- ❑ Other nasal problems
- ❑ Seizures
- ❑ Scalp pain and/or scalp problems
- ❑ Throat/voice problems or pain
- ❑ Whiplash

Internal Organs:
- ❑ Abdominal hernia
- ❑ Constipation
- ❑ Diarrhea
- ❑ Intestinal problems
- ❑ Kidney problems
- ❑ Liver
- ❑ Stomach problems
- ❑ Other internal organ problems

Lower Limbs - Legs/Knees/Ankles/Feet:
- ❑ Knee pain
- ❑ Leg pain
- ❑ Feet hurt
- ❑ Feet cold
- ❑ Feet numb or 'tingle-y'
- ❑ Sciatica

Male Concerns:
- ❑ Prostate concerns
- ❑ Performance concerns
- ❑ Testicle concerns
- ❑ Difficulties with urinating

Oral/TMJ:
- ❑ TMJ problems
- ❑ Teeth or bite problems
- ❑ Mouth/jaw pain
- ❑ 'Clicking'/'Popping' in jaws

Posture:
- ❑ Scoliosis
- ❑ 'Stoop-shouldered'
- ❑ 'Bad posture'

Skin:
- ❑ Rashes
- ❑ Unexplained redness
- ❑ Skin diseases, etc.
- ❑ Fungus infections

Upper Limbs - Shoulders/Arms/ Wrists/Hands
- ❑ Bursitis
- ❑ Carpal Tunnel (syndrome or surgery)
- ❑ Shoulder pain
- ❑ Elbow pain
- ❑ Wrist pain
- ❑ Hands cold
- ❑ Hands hurt
- ❑ Hands numb or 'tingle-y'

Name: ____________________________________ **Date:** _________________

Activities and Occupations Survey

Exploring repetitive motion & trauma for Facilitated Pathways Intervention

☐ Check the box by **ALL** activities you have done **intensively** or which have resulted in injury or significant pain ***at any time in your life.***

- ☐ Artist / craftsperson / flower-arranging, etc.
- ☐ Auto repair / auto bodywork
- ☐ Biting often & / or hard:
  - ☐ Grinding teeth (bruxing)
  - ☐ Chewing gum
  - ☐ Cracking hard candy or nuts
  - ☐ Chewing ice
- ☐ Bodyworker (in healthcare field)
- ☐ Boating:
  - ☐ Canoeing
  - ☐ Kayaking
  - ☐ Power-boats (motorboats, yachts)
  - ☐ Rowing / sculling
  - ☐ Sailing
- ☐ Computer work
- ☐ Chiropractor / Osteopath
- ☐ Construction work - painting - carpentry carpet-laying, roofing, , etc.
- ☐ Dancing – kind ? _____________________
- ☐ Dentist
- ☐ Dental technician
- ☐ Doctor - medical field? ________________
- ☐ Dispatching (using radio or telephone)
- ☐ Dog, cat, horse, (pet) grooming
- ☐ Driving
- ☐ Esthetician – doing facials, nails, make-up, etc
- ☐ Factory work
- ☐ Fishing – any kind, fly-rod to harpoon
- ☐ Furniture-moving
- ☐ Gardening
- ☐ Gun use – defense, hunting, target shooting
- ☐ Hair-stylist / barber
- ☐ Hiking
- ☐ Horseback riding / training
- ☐ Housekeeping / cleaning service
- ☐ Kneeling – for any activity
- ☐ Line-maintenance – phone, electric, etc.
- ☐ Musician –
  - ☐ string
  - ☐ keyboard / piano
  - ☐ brass
  - ☐ woodwinds
  - ☐ percussion
  - ☐ other ? ________________________
- ☐ Maintenance – kind? __________________
- ☐ Motorcycle, dirt-bike, motorbike
- ☐ Pest-control service – house, yard, plants
- ☐ Stock / shipping clerk
- ☐ Singing
- ☐ Smoking – cigs, cigars, pipe, etc.
- ☐ Surgeon - what kind?_______________
- ☐ Sports & Recreation
  - ☐ Archery
  - ☐ Bowling
  - ☐ Baseball
  - ☐ Basketball
  - ☐ Football
  - ☐ Golfing
  - ☐ Gymnastics
  - ☐ Ice Hockey
  - ☐ Ice skating / roller skating
  - ☐ Martial Arts - what? _______________
  - ☐ Roller-blading
  - ☐ Racquetball
  - ☐ Running / Jogging
  - ☐ Shooting pool
  - ☐ Snow-skiing
  - ☐ Soccer
  - ☐ Tennis
- ☐ Track / field (other than running) what?________________________
- ☐ Water Sports:
  - ☐ Diving
  - ☐ Jet-ski's
  - ☐ Swimming
  - ☐ Water-skiing
- ☐ Walking - for exercise, power-walking, race-walking
- ☐ Veterinarian
- ☐ Tai-Chi
- ☐ Telephone time - sales, telemarketing
- ☐ Truck driving <u>or</u> other extensive driving
- ☐ Waiter / Waitress / Bartending
- ☐ Weight lifting / strength-training
- ☐ Workouts (aerobic, trampoline, etc.)
- ☐ X-ray technician
- ☐ Yoga – traditional *or* power-yoga ☐

(Others ? – continue on back…)___

Name: ____ **Date:** _____________________

Birthdate: _____/_____/__________

I have listed all of my known medical conditions and physical limitations, and I will inform this provider of any changes in my physical health. I understand that a licensed health care provider who is treating me must be aware of all existing physical conditions that I have in order to provide appropriate and informed care.

I agree to pay for all services at the time they are rendered unless prior arrangements have been made.

____ ____________________

Signature Date

____

Name (please print)

I understand the information contained herein is privileged and confidential, and at this time I authorize the release of any information pertaining to my health to my attorney, insurance company, and/or referring physician(s) or therapist(s). Furthermore, I authorize the above persons to release any pertinent information about me, if needed, to this provider. I understand that this information will be treated as privileged and confidential.

____ ____________________

Signature Date

____

Name (please print)

Name: ____ **Date:** ______________________

Birthdate: _____/_____/__________

As responsible health care providers, the following health-related factors are important for us to know so we can provide you with the most appropriate and most effective care. Some of these factors also affect the precautions that our clinic must take to minimize the risks of spreading contagious conditions. In accordance with current laws and HIPAA, these healthcare concerns are considered **HIGHEST CONFIDENTIALITY TOPICS.**

Therefore, this page is NOT released to other health care providers, insurers, OR any other entity <u>except</u> by court order. *Thank you for your trust.*

- ❑ Drug Abuse
  - ❑ Alcohol (please check: ___ past ___ present)
  - ❑ Street Drugs (please check: ___ past ___ present)

    Which drugs? ______________________________________
  - ❑ Prescriptions (please check: ___ past ___ present)

    Which drugs? ______________________________________

- ❑ Abuse Survivor
  - ❑ Physical (please check: ___ past ___ present)
  - ❑ Emotional (please check: ___ past ___ present)

- ❑ Contagious Diseases
  - ❑ AIDS
  - ❑ HIV
  - ❑ STD(s) _________________________ (please check: ___ past ___ present)
  - ❑ Hepatitis - Type _____ (please check: ___ past ___ present)

- ❑ ___________________________________
- ❑ ___________________________________
- ❑ ___________________________________

____ ____________________

Signature Date

____

Name (please print)