M.T. Wellness Clinic
Patient Information Form

Last Name: _____ First Name: _____ Date of birth: _____

Gender: ☐ Male ☐ Female ☐ Other Insurer: _____

Address: _____ City/State/Zip: _____

Primary Phone: _____ Alternate Phone: _____ E-mail: _____

May we send you occasional correspondence via email? ☐ Yes ☐ No

Emergency contact: _____ Relationship: _____ Phone: _____

Employment Status: ☐ Full time ☐ Part time ☐ Unemployed ☐ Retired

Do you: ☐ Sit for long periods? ☐ Stand for long periods? ☐ Lift over 25 pounds?

How did you find out about our clinic? ☐ Referral ☐ Internet ☐ Direct Mail ☐ Print Advertising (newspaper, magazine, etc.) ☐ Other: _____

If you were referred to our clinic, who referred you? ☐ Physician ☐ Other Medical ☐ Family ☐ Friend ☐ Co-worker ☐ Other: _____

What is the reason for your visit? ☐ Pain ☐ Loss of function ☐ Both ☐ Other: _____

If you're experiencing pain:

Are the episodes ☐ Intermittent? ☐ Constant?

If constant, has the pain been present for ☐ Less than 3 months? ☐ More than 3 months?

How long do symptoms typically last? _____

With regard to your symptoms, what makes them:

Better? _____

Worse? _____

Please identify body region(s) affected (select all that apply): ☐ Head/neck ☐ Upper extremity (shoulder, arm, elbow, forearm, wrist, hand) ☐ Chest/abdomen ☐ Back ☐ Buttock/groin/hip ☐ Lower extremity (thigh, knee, leg, ankle, foot)

What outcomes are you hoping to achieve from your MRMT ® treatments? ☐ Reduced pain or discomfort ☐ Increased function or mobility ☐ Improved range of motion ☐ Improved posture ☐ Improved stability or balance ☐ Improved quality of sleep ☐ Reduced symptoms for chronic condition ☐ Reduced frequency of flare-ups ☐ Stress reduction

Please indicate any treatments you are currently receiving, along with the outcome for each:

	Currently Receiving?	Positive	Neutral	Negative
Physical Therapy	☐	☐	☐	☐
Chiropractic Care	☐	☐	☐	☐
Acupuncture	☐	☐	☐	☐
Traditional Massage	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐

Please indicate and list any medications you are taking to address your pain or dysfunction:

☐Pain reliever: _____

☐Muscle relaxer: _____

☐Anti-inflammatory: _____

☐ Anti-depressant: _____

☐Anti-anxiety: _____

☐Anti-convulsant: _____

☐Sleep aid: _____

☐Other (please list): _____

P*lease list any hobbies, stress reduction or exercise/sports in which you currently participate:*

_____

_____

Health history – please select all conditions that you have experienced:

Muscles and bones:☐Low back, hip, leg pain ☐Neck, shoulder, arm pain ☐Headaches/ head injuries

☐Sprain/strain ☐Spasms/cramps ☐Osteoarthritis ☐Bone or joint disease ☐Tendonitis ☐Bursitis

☐Jaw pain/TMJ ☐Broken/fractured bones ☐Lupus ☐Fibromyalgia

☐Other: _____

Heart, lungs and blood vessels:☐Heart condition ☐Blood clots ☐High blood pressure ☐Low blood pressure

☐Lymphedema ☐Difficulty breathing ☐Asthma ☐Sinus problem ☐Varicose veins

☐Other: _____

Skin and allergies:☐Rashes ☐Athlete's foot ☐Warts ☐Allergies

☐Other: _____

Nerves and sensations:☐Shingles/herpes ☐Fatigue ☐Sleep disorders ☐Autoimmune disorders

☐Decreased/unusual sensations

☐Other: _____

Digestion:☐Constipation ☐Gas/bloating ☐Diverticulitis ☐Irritable Bowel Syndrome (IBS)

☐Other: _____

Women's health:☐PMS ☐Perimenopause ☐Menopause ☐Pregnancy (stage) _____

☐Other: _____

Other health issues:☐Diabetes ☐Depression/anxiety ☐Drug/alcohol use ☐Nicotine/caffeine use

☐Eating disorders ☐Infectious disease: _____

☐Cancer/tumors: _____

☐Other: _____

Please list and date any surgeries that you have had:

_____

_____

_____

_____

100%	Completely able to function; no limitations in any activities
90%	Extremely functional; tolerable difficulties for one or two activities
80%	Very functional; tolerable difficulties for a few activities
70%	Mostly able to function; tolerable difficulties for some activities
60%	Able to function; tolerable difficulties for many activities
50%	Somewhat able to function; tolerable difficulty for most activities
40%	Limited in ability to function; require assistance for a few daily activities
30%	Somewhat limited in ability to function; require assistance for some daily activities
20%	Very limited in ability to function; require assistance for many daily activities
10%	Extremely limited in ability to function; require assistance for most daily activities
0	Unable to function; unable to perform any daily activities without assistance

Based on the table above, please rate your current function level for each of the following activities:

	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0
Standing	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sitting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sleeping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Running	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bending	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reaching	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grasping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Standing up	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sitting down	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Turning/Twisting	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rolling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Squatting/Kneeling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Getting in and out of bed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ascending/Descending stairs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lifting/Carrying	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Driving a car	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Performing your job	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Typing/Computer use	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other:_____ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Other:_____ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

I attest that I have answered the questions above completely and honestly to the best of my ability.

Patient Signature: _____ Date: _____

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