

Patient History

Date: _____

Name: _____ Birthdate: _____

Address: _____

City: _____ State _____ Zip _____

Occupation: _____

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

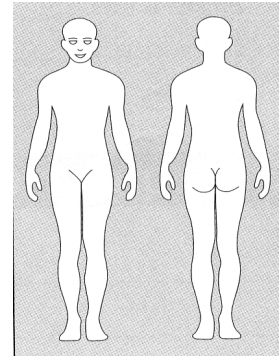
Type of pain: Sharp Dull Throbbing Numbness Aching

Shooting Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain _____

Is it constant or does it come and go? _____

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



Medical History (Please Mark all that apply)

Loss of Hearing

Ringing in Ears

Ear Infections

Poor Vision

Double Vision

Eye Pain

Eye Infections

Nose Bleeds

Sinus Trouble

Sore Throat

Allergies

Hoarseness

Pneumonia

Bronchitis

Asthma

Shortness of Breath

Thyroid Disease

Back Pain

Rashes

Insomnia

Memory Loss

Dizzy Spells

Hypertension

Heart Murmur

Palpations

Irregular Pulse

Swollen Ankles

Fainting Spells

Chest Pain

Numb Arm or Leg

Loss of Appetite

Indigestion

Stomach Ulcers

Diarrhea

Constipation

Bloody Stools

Tarry Stools

Nervousness

Moodiness

Depression

Phobias

Mental Illness

Hemorrhoids

Blood in Urine

Frequent Urination

Hernia

Gallbladder Disease

Kidney Disease

Sudden Weight Loss

Fatigue

Anemia

Cancer

Diabetes

Stroke

Convulsions

Broken Bones

Headaches

Joint Pain

Chicken Pox

Measles

Polio

Mumps

Tuberculosis

CranioSacral Institute of Michigan, LLC

Medications

(List any medications you are currently taking.)

Allergies

(List any allergies)

What treatment have you already received for your condition?

- Medications Surgery Chiropractic Services
 Physical/Occupational Therapy CranioSacral Therapy
 None
 Other _____

Injuries/Surgeries**Description****Date**

Falls _____
Head Injuries _____
Broken Bones _____
Surgeries _____
Birth Trauma/Injury _____

Exercise: None Moderate Daily Heavy

Work Activity: Sitting Standing Light Labor Heavy Labor Mixed

Habits: Smoking Alcohol
 Packs/day: _____ Drinks/Week: _____
 Coffee/Caffeine High Stress Level
 Cups/Day: _____ Reason _____

If you have any questions regarding this form, or if there is other information which you have and which you feel might be important, please discuss it with your physical/occupational therapist. Also, if any of the information which you have provided should change, you should inform your physical/occupational therapist.

Signature: _____

Date: _____

51850 Dequindre Rd., Suite 1, Shelby Township, Michigan 48316
(586) 991-0801