

The Centered Body: History Form

File: _____ Date: _____

Please Print

Last Name: _____

Birth date: _____ Age: _____

First Name: _____

Title with last Name: Dr. Mr. Mrs. Ms. Miss

How would you like to be addressed?

First Name? _____ Nickname/Other: _____

Address: _____ E-Mail: _____

City: _____ State: _____ Zip Code: _____ Gender: Male Female

Phone: Day (____) _____ Night: (____) _____ Which Prefer? _____

Referred By: _____ Emergency Name/Phone: _____

Select one answer in each of the items below:

OCCUPATION

Professional/Technical

Tradesman/Craftsman

Clerical/Office

Homemaker

Production/Manufacturing

Service/Retail

MARITAL STATUS

Married/Partnered

Widowed

Separated

Divorced

Never married/partnered

EDUCATION LEVEL

Less than 12 years

High School Graduate

1-4 years College

Beyond 4 years of College

Post-graduate/Professional School

Trade School/Other

Do You NOW have any of the following conditions? (MARK IF YES)

Congestive heart failure?

Sciatica or chronic back problem?

Chronic lung disease (including bronchitis or emphysema)?

Hypertension/High Blood Pressure (HBP)?

Blindness or trouble seeing, even when wearing corrective lens?

Angina?

Deafness or trouble hearing?

Heart attack or myocardial infarct (MI)?

Sugar Diabetes (Diabetes mellitus Type I)?

Stroke or transient ischemic attacks (TIA)?

Sugar Diabetes (Diabetes mellitus Type II Adult Onset)?

Kidney disease?

Asthma/allergies?

Cancer

Ulcer or gastrointestinal bleeding (not including hemorrhoids)?

Depression/Sadness/Anxiety

Arthritis or rheumatism?

Other: _____

0 Do Not Smoke If you smoke cigarettes, how many do you smoke in an average day?

Less than 1/2 pack

1/2 to 1 pack/day

1 to 2 packs/day

More than 2 packs

0 Do Not Drink

If you drink alcohol, how many drinks in an average day?

(One drink is a bottle of beer, a glass of wine, one cocktail, etc.)

< One

No more than one

1 -2 drinks

3 - 5 drinks

6 - 8 drinks

8+ drinks

Are you taking any medications? No Yes If YES, please identify: _____

Please Turn Over and Complete Following Page....

Describe your **MAIN PROBLEM** at this time: _____

What **OTHER muscle - bone - joint problems** bother you right now? _____

When did your CURRENT episode start? Date: _____
(Include at least month and year, if known)

What is your history with this injury/complaint? **Sudden Incident** **Re-occurrence** **Ongoing**

What makes the pain go away or feel better? _____

What makes the pain worse? _____

How would you describe your pain (i.e., sharp, stabbing, prickly, hot, dull, deep, throbbing, gnawing, etc.)?

Does your pain travel, or can you feel it somewhere else on your body?

Where on your body do you feel the pain, pinching, tightness, or discomfort?

At what time of the DAY or WEEK is your pain worst?

The pain/discomfort is...

Intermittent (comes and goes) It usually lasts for: _____ **Minute(s)** **Hour(s)** **Day(s)** **Week(s)**

Constant Other: _____

How long have you been having pain/ this problem in the past?	How many times have you discomfort?	When did you first have these or similar symptoms?
<input type="checkbox"/> 1 week or less	<input type="checkbox"/> Never	<input type="checkbox"/> Never
<input type="checkbox"/> 1 to 6 weeks	<input type="checkbox"/> 1 to 3 episodes	<input type="checkbox"/> < 6 months ago
<input type="checkbox"/> > 6 weeks but < 3 months	<input type="checkbox"/> 4 or more episodes	<input type="checkbox"/> 6 months to 1 year
<input type="checkbox"/> 3 months to 1 year		<input type="checkbox"/> More than 1 year ago

Home: Toddler/Baby Stairs Sleep stomach New mattress/pillow Lifting/Carrying Changes to routine

Job: Sit 3+ hrs/day Computer 3+ hrs/day Phone 3+ hrs/day Stairs Lifting/Carrying Commute 30m+

Change in workspace/chair Frequent Travel: ____ Air ____ Car

Other: Right-handed Left-handed "New" car last 6 months Manual Transmission

YES Motor Vehicle Accident **YES** Job Injury **YES** Other Personal Injury **YES** At-home Trauma

What is your goal of care/treatment at this facility? _____
