Healing In Motion PLLC Therapy and Wellness Center
5340 Plymouth Rd, Ste.100 Ann Arbor, MI 48105 Phone 734.913.4816 Fax 734.913.8021

Patient Health & History

To ensure you receive a complete and thorough evaluation, please provide this background information.

Name: _____ Date of Birth: _____ Age: _____

Occupation: _____ Leisure Activities/ Sports: _____

Are you currently seeing any of the following?

_____ Medical Doctor (MD, DO)
_____ Psychiatrist/Psychologist
_____ Osteopath
_____ Physical therapist
_____ Dentist
_____ Chiropractor
_____ Personal Trainer
_____ Massage Therapist

If you have seen or been referred to any of the above during the past three months, please describe the **reason for the referral and the result**. _____

_____

Who referred you to our clinic? _____

Have you ever been diagnosed as having any of the following conditions?

YES NO Cancer If yes, what kind:_____
YES NO Heart problems
YES NO High blood pressure
YES NO Asthma
YES NO Emphysema/Bronchitis
YES NO Thyroid problems
YES NO Diabetes
YES NO Multiple sclerosis
YES NO Rheumatoid arthritis
YES NO Other arthritic conditions
YES NO Depression
YES NO Hepatitis
YES NO Tuberculosis
YES NO Stroke
YES NO Kidney disease
YES NO Anemia
YES NO Epilepsy
YES NO Incontinence
YES NO Chemical dependency (i.e. alcoholism)

Are you pregnant? Y / N Number of pregnancies _____ Number of births _____

Please list any surgeries or conditions you have been hospitalized for, the reason and the approximate date: _____

_____

_____

Please list any injuries for which you have been treated and the approximate date: _____

_____

_____

Which of the Over-the-counter medications have you taken in the last week?

_____ Aspirin
_____ Tylenol
_____ Laxatives
_____ Decongestants
_____ Antihistamines
_____ Antacid
_____ Vitamins/mineral supplements
_____ Advil/Motrin/Ibuprofen/Aleve

Please list any prescription medication you are currently taking (Including pills, injections and skin patches): _____

_____

_____

How many caffeinated beverages do you have per day? _____

How many cigarettes do you smoke a day? _____ If none, have you ever smoked? _____

How many days per week do you drink alcohol? _____ How many drinks per day? _____

How many days per week do you use recreational drugs (marijuana, cocaine, crack, meth, etc)? _____

Have you recently noted any of the following?

YES NO Weight loss or gain YES NO Nausea or vomiting YES NO Fatigue
YES NO Weakness YES NO Numbness or tingling

Please explain the reason for your visit today: _____

Date of injury or onset: _____ Work Related **Y / N** Auto Accident **Y / N** Other: _____

Please explain how the injury occurred: _____

_____

Have you had this injury/condition/pain before? **Y / N** When?_____

What treatment have you received for it before now?_____

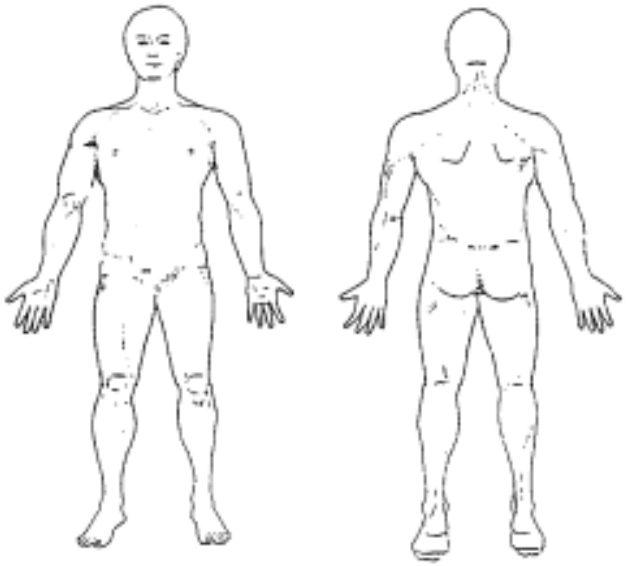
When and where?_____

Please indicate your level of pain: 0- no pain 10- going to ER

0 1 2 3 4 5 6 7 8 9 10

Lowest/Best /10 Current /10 Highest/Worst /10

Please indicate on the picture your current feeling of pain, numbness, tingling or any other sensory difficult



Patient Signature:_____ **Date:** _____