Name: _____ Date of birth: _____

Please briefly describe the problem you are here for today: _____
_____
What is your goal for therapy? _____
_____

Have you recently noted any of the following symptoms? (Check all that apply)

☐ Unexplained Weight Loss ☐ Changes in Appetite ☐ Headaches ☐ Fever/Chills/Sweats
☐ Poor Balance/Falls ☐ Numbness/Tingling ☐ Difficulty Swallowing
☐ Dizziness/Lightheadedness ☐ Shortness of Breath ☐ Increased Pain at Night
☐ Changes in Bowel or Bladder Function

Do you have a pacemaker / defibrillator? ◯ Yes ◯ No
Are you allergic to latex? ◉ Yes ◯ No
Are you allergic to any steroids, including topical steroids (dexamethasone)? ◯ Yes ◯ No
Are you allergic to adhesive (band-aids, tape, etc)? ◯ Yes ◯ No
For Women: Are you currently pregnant or think you might be pregnant? ◯ Yes ◯ No

Have you fallen in the past year? ◯ Yes ◯ No
Do you feel unsteady when standing or walking? ◯ Yes ◯ No
Do you worry about falling? ◯ Yes ◯ No

Is this due to an accident? ◯ Yes ◯ No
Is this related to a Worker's Compensation Claim? ◯ Yes ◯ No
Date of onset of symptoms (roughly at least) or Date of Accident? _____
Still employed? ◯ Yes ◯ No Last day of job: _____
Where do you work? _____
What do you do at your job? _____

Have you had any physical, occupational, or speech therapy this year? _____
If yes, how many visits? _____ and at what facility? _____
Have you had any chiropractic visits this year? _____
If yes, how many visits? _____ and at what facility? _____
For Medicare patients: Are you receiving any kind of home health care at this time? _____
If yes, what home health agency? _____