# PATIENT INFORMATION

Welcome! Thank you for selecting our practice. In order to serve you properly, we will need the following information. All information will be kept strictly confidential. (Please print)

Patient Name _____

Street _____ City _____

State (Prov) _____ Country _____ Zip Code _____

Home Phone _____ Cell _____ Work _____

Email _____ Date of Birth _____

Single _____ Married _____ Divorced _____ Separated _____ Widowed _____ Partnered _____

Employer _____ Occupation: _____

Address _____

Employer Phone _____

In case of emergency, please provide the name of a contact person/nearest relative not residing with you.

Name _____ Phone _____

Relationship _____

*I understand that payment is expected at the time of service. I am responsible for all charges/fees regardless of insurance coverage. I also understand that Dr. Giammatteo, DC, PT, IMTC, is a non-participating Medicare provider and payment is expected at time of service.*

Patient Signature _____ Date _____

Office Use: Reviewed _____ Date_____


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# INTAKE INFORMATION

DATE _____ PATIENT NAME _____CURRENT AGE _____

Please complete the following information in detail. This will assist us in designing the most effective and efficient individualized program for you. Every item is significant and important. Thank you for your effort. Please print neatly.

Who referred you to this office? _____

Official diagnosis or main problem: _____

_____

Reason for visit if different from above _____

**IMPORTANT:**
To the patient: Please list below the main complaints/challenges you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

| | DATE OF LAST EXAM | DOCTOR'S NAME | DOCTOR'S PHONE # |
|---|---|---|---|
| **PHYSICAL EXAM** | | | |
| **SPECIALIST(S)** | | | |
| **OBGYN (FEMALE)** | | | |


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Patient Name/Initials: _____

Please report all current areas of pain and the usual range of pain for that area in the column to the right of that area. For example, Head 4-7.

Ranges of Pain: 0 no pain – 10 excruciating/debilitating pain

| | | | | | |
|---|---|---|---|---|---|
| Head | | Right lower arm | | Right front thigh | |
| Face | | Left lower arm | | Left front thigh | |
| Jaw | | Right wrist | | Right back thigh | |
| Front of neck | | Left wrist | | Left back thigh | |
| Back of neck | | Right fingers | | Right knee | |
| Right side of neck | | Left fingers | | Left knee | |
| Left side of neck | | Upper Back | | Right shin | |
| Right shoulder | | Chest/Rib cage | | Left shin | |
| Left shoulder | | Abdomen | | Right foot | |
| Right upper arm | | Low back | | Left foot | |
| Left upper arm | | Buttocks | | | |
| Right elbow | | Right hip | | | |
| Left elbow | | Left hip | | | |

Please place a checkmark in the box beside the activity if it makes your pain *worsen*.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lying down | | Sitting | | Standing | | Walking | |
| Driving | | Running | | Working | | Time of day | |
| Too much activity | | Bending | | Reaching | | Lifting | |
| Squatting | | Kneeling | | Too little activity | | Other: | |

Explain/Other: _____

_____

Please place a checkmark in the box beside the activity if it makes your pain *decrease*.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lying down | | Sitting | | Standing | | Walking | |
| Driving | | Running | | Working | | Time of day | |
| Too much activity | | Bending | | Reaching | | Lifting | |
| Squatting | | Kneeling | | Too little activity | | Other: | |

Explain/Other: _____

_____

When did your pain begin? (Weeks, months, years ago?) _____

Was your onset of pain sudden? _____ Was your onset of pain gradual? _____

Explain if necessary _____


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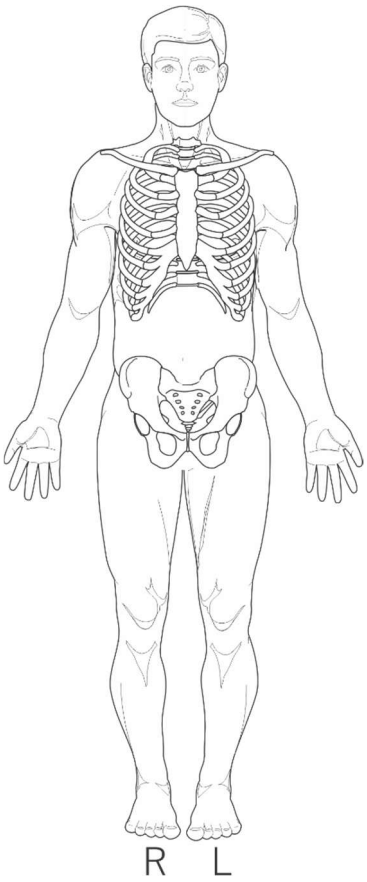
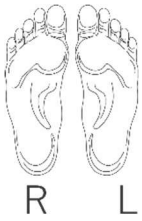
Patient Name/Initials: _____

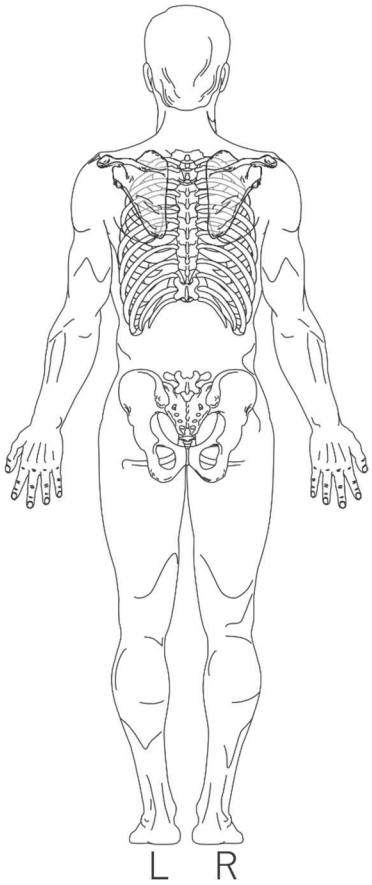
**Pain Diagram:** Please shade in all areas of pain. Be as thorough and specific as possible.

**Front**

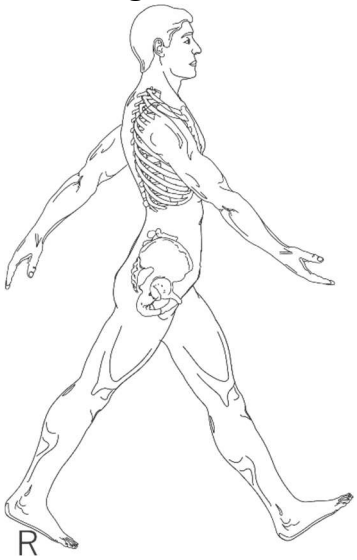


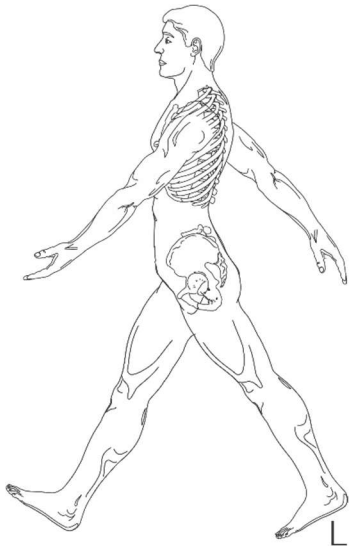

**Back**




**Right Side**




**Left Side**





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Patient Name/Initials: _____

**Paresthesia:** Please check the following areas of "funny feeling" (tingling, burning, pins and needles, etc.)

| | | | | | |
|---|---|---|---|---|---|
| Head | | Right lower arm | | Right front thigh | |
| Face | | Left lower arm | | Left front thigh | |
| Jaw | | Right wrist | | Right back thigh | |
| Front of neck | | Left wrist | | Left back thigh | |
| Back of neck | | Right fingers | | Right knee | |
| Right side of neck | | Left fingers | | Left knee | |
| Left side of neck | | Upper back | | Right shin | |
| Right shoulder | | Chest/ Rib Cage | | Left shin | |
| Left shoulder | | Abdomen | | Right Foot | |
| Right upper arm | | Low back | | Left foot | |
| Left upper arm | | Buttocks | | | |
| Right elbow | | Right Hip | | | |
| Left elbow | | Left Hip | | | |


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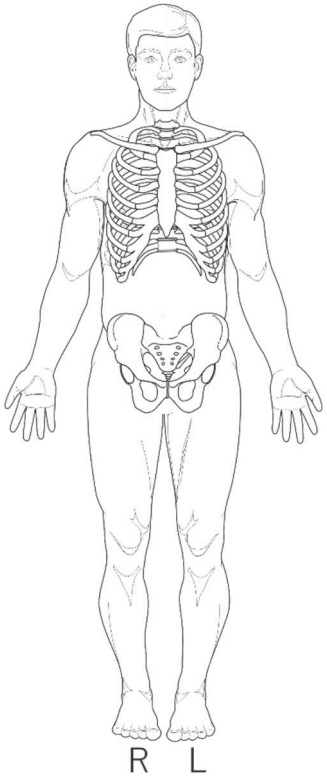
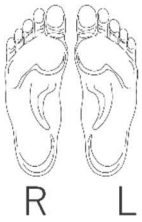
Patient Name/Initials: _____

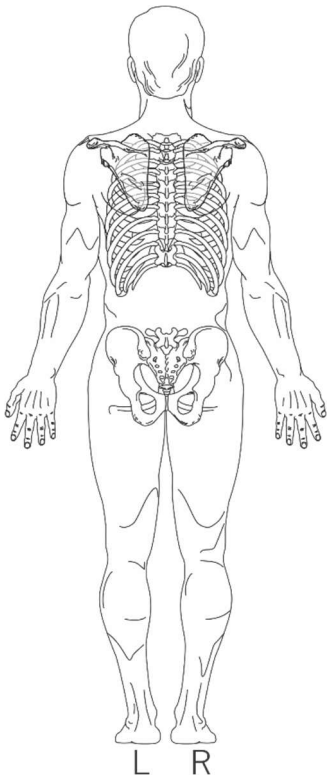
Paresthesia Diagram: Please shade in all areas of "funny feeling" (tingling, burning, pins and needles, etc.)

**Front**

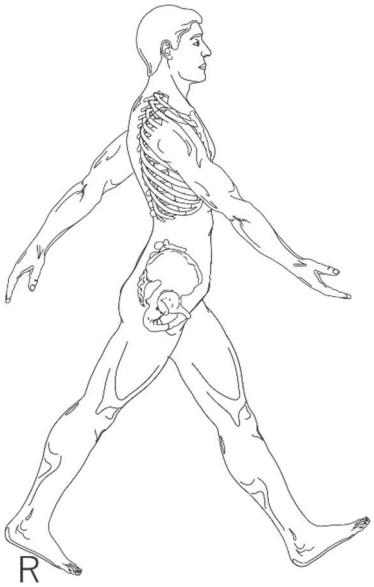


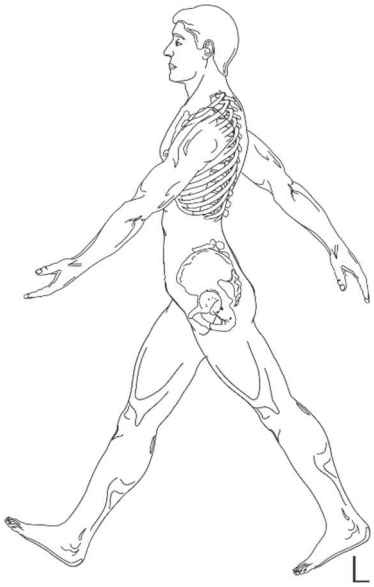

**Back**




**Right Side**




**Left Side**



Patient Name/Initials: _____

Please tell us about your symptoms by checking the appropriate areas under Frequency and under Severity:

| | Frequency | | | | Severity | | |
|---|---|---|---|---|---|---|---|
| | Occasional | Often | Constant | | Mild | Moderate | Severe |
| Dizziness, lightheaded | | | | | | | |
| Fainting | | | | | | | |
| Decreased concentration/attention | | | | | | | |
| Short term memory loss | | | | | | | |
| Slurred speech | | | | | | | |
| Balance or coordination problems | | | | | | | |
| Headaches | | | | | | | |
| Nausea | | | | | | | |
| Indigestion | | | | | | | |
| Difficulty swallowing | | | | | | | |
| Ears: ringing, stuffy, painful | | | | | | | |
| Vision: blurring, burning, aching, pressure, change, double | | | | | | | |
| Drooping eyelid or any changes in pupils | | | | | | | |
| Allergies | | | | | | | |
| Sinus problems | | | | | | | |
| Nagging cough, hoarseness | | | | | | | |
| Chest pain | | | | | | | |
| Cold hands | | | | | | | |
| Cold feet | | | | | | | |
| Stiffness | | | | | | | |
| Bowel problems | | | | | | | |
| Unusual bleeding or discharge | | | | | | | |
| Sexual function problems | | | | | | | |
| Change in any wart or mole | | | | | | | |
| Sore that does not heal | | | | | | | |
| Thickening in breast/elsewhere | | | | | | | |
| Snoring | | | | | | | |
| Pain wakes you from a sound sleep | | | | | | | |
| Night sweats | | | | | | | |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Patient Name/Initials: _____

**Function:** Activities of Daily Living (ADL) are compromised as follows:

| | | | | |
|---|---|---|---|---|
| **Bed activities:** | Lying on stomach is | Painful | Difficult | Not possible |
| | Lying on back is | Painful | Difficult | Not possible |
| | Lying on right side is | Painful | Difficult | Not possible |
| | Lying on left side is | Painful | Difficult | Not possible |
| | Rolling over in bed is | Painful | Difficult | Not possible |
| **Transfer activities:** | Lying to sit is | Painful | Difficult | Not possible |
| | Sitting to lying is | Painful | Difficult | Not possible |
| | Sitting to standing is | Painful | Difficult | Not possible |
| **Standing is:** | | Painful | Difficult | Not possible |
| | Present standing tolerance: _____ min/hours | | | |
| **Sitting is:** | | Painful | Difficult | Not possible |
| | Present sitting tolerance: _____ min/hours | | | |
| **Driving is:** | | Painful | Difficult | Not possible |
| | Present driving tolerance in car: _____ min/hours | | | |
| **Sitting in a car is:** | | Painful | Difficult | Not possible |
| | Present sitting tolerance in car: _____ min/hours | | | |
| **Walking is:** | | Painful | Difficult | Not possible |
| | Present walking tolerance: _____ min/hours/miles | | | |
| **Running is:** | | Painful | Difficult | Not possible |
| | Present running tolerance: _____ min/hours/miles | | | |
| **Work is:** | | Painful | Difficult | Not possible |
| | Present work tolerance: _____ min/hours | | | |
| **Stairs are:** | | Painful | Difficult | Not possible |
| **Bending and lifting activities are:** | | Painful | Difficult | Not possible |
| **Reaching with arms is:** | | Painful | Difficult | Not possible |
| **Sport and leisure activities are:** | | Compromised | | Not possible |

**All activities/ADL are performed despite:** Pain Fatigue Lack of energy Headaches

Other: _____


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Patient Name/Initials: _____

How many hours do you sleep at night? _____

How many hours per day (in 24 hours) do you spend in bed? _____

How would you consider your present level of activity? _____ Poor _____ Fair _____ Good

Please list your present hobbies: _____

_____

**Work/Occupation:**

Please state what you do for a living _____

Please indicate the hours you spend at work per week _____

Or if you are currently not working, how long have you not worked? _____

Are you not working for reasons other than your pain/problem? _____ Yes _____ No

If so, what is the reason? _____

_____

Are you a full-time homemaker? _____ Yes _____ No

| | Before pain/disability | After pain/disability |
|---|---|---|
| Hours per week spent working at a paying job | | |
| Hours per week doing household chores | | |
| Hours per week spent doing a volunteer job | | |

Are you presently receiving compensation (disability insurance)? _____ Yes ____ No

If not, are you considering or have you applied for compensation of any kind? _____ Yes ____ No

If you anticipate returning to work, when do you hope to do so? _____

_____

Please describe how your present living situation is different from the way it was before you experienced pain/disability problems _____

_____

_____


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Patient Name/Initials: _____

Please place a check mark under either Yes or No

| **Current Assistive Devices:** | YES | NO |
|---|---|---|
| Cane | | |
| Walker | | |
| Manual Wheelchair | | |
| Motorized Wheelchair | | |
| Corrective lenses/glasses | | |
| Hearing aids | | |
| Dentures | | |
| Prosthetics | | |
| Shunts | | |
| Pacemaker | | |
| Insulin Pump | | |
| Baclofen Pump | | |
| Other | | |

| **Present Home Environment:** | YES | NO |
|---|---|---|
| Stairs, no railing | | |
| Stairs with railing | | |
| Ramps | | |
| Elevator | | |
| Uneven terrain | | |
| Bathroom modifications | | |

Explain if other obstacles _____

**Current and Past Medical History:** Please fill in blanks that apply

| | **Date:** | **Treatment:** | **Resolved? (Y/N)** |
|---|---|---|---|
| Abuse History | | | |
| Alcoholism | | | |
| Allergies | | | |
| Alzheimer's Disease | | | |
| Anxiety | | | |
| Apnea | | | |
| Arthritis | | | |
| Asthma | | | |
| Attention Deficit Disorder (ADD) | | | |
| Attention Deficit(ADHD) Hyperactivity Disorder | | | |
| Autoimmune Disease | | | |
| Babesia Borrelia | | | |
| Back pain | | | |
| Bronchitis | | | |
| Cancer/What Type? | | | |
| Candida | | | |


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Patient Name/Initials:_____

Please continue filling in blanks where applicable

| | Date: | Treatment: | Resolved?(Y/N) |
|---|---|---|---|
| Carpal Tunnel Syndrome | | | |
| Cerebral Palsy | | | |
| Elevated Cholesterol | | | |
| Chron's Disease | | | |
| Chronic Fatigue Syndrome | | | |
| Circulatory Problems | | | |
| Colitis | | | |
| Colonoscopy | | | |
| Dental Problems | | | |
| Depression | | | |
| Diabetes | | | |
| Diverticular Disease | | | |
| Drug Addiction | | | |
| Eating Disorder | | | |
| Epilepsy | | | |
| Environmental Sensitivities | | | |
| Ehlers-Danlos/Connective Tissue disorder | | | |
| Eyes, ears, nose, throat problems | | | |
| Facial Palsy | | | |
| Fibromyalgia | | | |
| Food intolerance | | | |
| Gastrointestinal | | | |
| Genetic Disorder | | | |
| Glaucoma | | | |
| Gout | | | |
| Headaches: Frequency? Duration/Intensity1-10 | | | |
| Heart Disease | | | |
| Hemorrhoids | | | |
| High Blood pressure | | | |
| Infection, Chronic (type) | | | |
| Inflammatory Bowel Disease | | | |
| Irritable Bowel Syndrome | | | |
| Kidney/Bladder disease | | | |
| Learning Disabilities | | | |
| Liver/Gallbladder Disease (stones) | | | |
| Lymphedema | | | |
| Lymphatic problems | | | |
| Lyme Disease | | | |
| Mental Health Illness/Issue | | | |
| Mental Retardation | | | |
| Mold Exposure | | | |


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Patient Name/Initials:_____

Please continue filling in blanks where applicable

| | Date: | Treatment: | Resolved?(Y/N) |
|---|---|---|---|
| Mononucleosis/Epstein Barr | | | |
| Multiple Sclerosis | | | |
| Musculoskeletal problems | | | |
| Obesity | | | |
| Osteoporosis | | | |
| PTSD | | | |
| Panic Attacks | | | |
| Paraplegia | | | |
| Parkinson's | | | |
| Phobias | | | |
| Pneumonia | | | |
| Quadriplegia | | | |
| Respiratory problems | | | |
| Rheumatoid Arthritis | | | |
| Seasonal Affective Disorder | | | |
| Sexually Transmitted Disease | | | |
| Sleeping Difficulty | | | |
| Sinus problems | | | |
| Skin Problems | | | |
| Spina bifida | | | |
| Stroke | | | |
| Tattoos | | | |
| Thyroid Problems | | | |
| Traumatic History | | | |
| Traumatic Brain Injury (TBI) | | | |
| Tuberculosis | | | |
| Ulcer | | | |
| Urinary Tract Infection | | | |
| Varicose Veins | | | |
| Yeast Infection | | | |
| Other | | | |
| Other | | | |
| Other | | | |


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Patient Name/Initials:_____

**Men:**

| | **Date:** | **Treatment:** | **Resolved?(Y/N)** |
|---|---|---|---|
| Last PSA | | | |
| Benign Prostatic Hypertrophy | | | |
| Decreased Sex Drive | | | |
| Infertility | | | |
| Prostate Cancer | | | |
| Sexually Transmitted Disease | | | |
| Other | | | |
| Other | | | |

**Women:**

| | **Date:** | **Treatment:** | **Resolved?(Y/N)** |
|---|---|---|---|
| Last OBGYN Appt | | Pap? (Y/N) Mammo? (Y/N) | |
| Childbirth | | C-Section? (Y/N) | |
| Breast Cancer | | | |
| Breast Surgery/ Reduction/Implants | | | |
| Decreased Sex Drive | | | |
| Endometriosis | | | |
| Fibrocystic Breasts | | | |
| Fibroids/Ovarian Cysts | | | |
| Infertility | | | |
| Menstrual irregularities | | | |
| Date of last menses | | | |
| Pelvic Inflammatory Disease | | | |
| PMS | | | |
| Sexually Transmitted Disease | | | |
| Vaginal Infections | | | |
| Other | | | |
| Other | | | |


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Patient Name/Initials:_____

List all trauma and when it occurred (All trauma, accidents, injuries are important, not just recent ones):

_____
_____
_____
_____
_____
_____

List any operations you have undergone and approximate dates:

_____
_____
_____
_____

List any hospitalizations and approximate dates:

_____
_____
_____
_____

**Vaccinations/Inoculations:** Please list any vaccinations or inoculations you have received below:

| Date | Name of Vaccination/Inoculation | Did you become ill? |
|---|---|---|
| | | |
| | | |
| | | |

**Travel-Out of the Country:** When/Where have you traveled out of the country?

| Date | Country | If inoculation required, list below | Did you become ill? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Are you losing weight without trying? _____ Yes _____ No

Are you coughing up blood or noticing blood in your stool or urine? _____ Yes _____ No

Have you lost consciousness or had double vision recently? _____ Yes _____ No


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Patient Name/Initials: _____

**Family Health History:** Please fill in blanks where applicable

| | |
|---|---|
| Alcoholism | |
| Alzheimer's Disease | |
| Arthritis | |
| Asthma | |
| Cancer | |
| Depression | |
| Diabetes | |
| Drug Addiction | |
| Eating Disorder | |
| Genetic Disorder | |
| Glaucoma | |
| Heart Disease | |
| High Blood Pressure | |
| Infertility | |
| Learning Disabilities | |
| Mental Illness | |
| Mental Retardation | |
| Migraine Headaches | |
| Neurological Disorders (Parkinson's, Paralysis) | |
| Obesity | |
| Osteoporosis | |
| Rheumatoid Arthritis | |
| Stroke | |
| Other | |
| Other | |

**Health Habits:**

Tobacco: *How many per day?* Cigarettes _____ Cigars _____ Pipe _____ Chewing _____
Cannabis: THC or CBD Use? _____ Form of Intake: _____
Alcohol: *How many per day and per week?* Wine or beer (glass) ____ /____ Ounces of Liquor ____ / ____
Caffeine: *How many per day?* Coffee (6 oz cup ) _____ Tea (6 oz. cup) _____
Soda (caffeinated) cans _____ Soda (Diet) cans _____

**Exercise:** (Check *all* that apply)

| | 5-7 days per week | 3-4 days per week | 1-2 days per week | Infrequently | Never | 45 min. or more per workout | 30-45 min. per workout | 30 min. or less |
|---|---|---|---|---|---|---|---|---|
| Swim | | | | | | | | |
| Walk | | | | | | | | |
| Run, jog, jump rope | | | | | | | | |
| Boxing | | | | | | | | |
| Yoga | | | | | | | | |
| Other | | | | | | | | |

Patient Name/Initials: _____

**Nutrition & Diet:** Please check whichever is applicable.

| | |
|---|---|
| Vegetarian | |
| Vegan | |
| High Protein | |
| Salt Restriction | |
| Low Fat Diet | |
| Starch/Carbohydrate Restriction | |
| The Zone Diet | |
| Atkins Diet | |
| Paleo / Keto | |
| Other | |

**Specific Food Restrictions:**

| | |
|---|---|
| Dairy | |
| Eggs | |
| Soy | |
| Corn | |
| Gluten | |
| Wheat | |
| Sugar | |
| Other | |

Circle the level of stress you are experiencing on a scale of 1-10 with 1 being the lowest

1 2 3 4 5 6 7 8 9 10

Identify and list the major causes of stress (changes in job, work, residence, finances, or legal problems)

_____

_____

_____


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Patient Name/Initials: _____

Please list any prescribed, over-the-counter medications and/or supplements you are presently taking. Attach another piece of paper if needed.

| Present Prescriptions/Over-the-counter Medications | Dosage | For how long? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

| Present Supplements | Dosage | For how long? |
|---|---|---|
| | | |
| | | |
| | | |

Please list those taken and discontinued in the past 5 years _____

_____

While you are a patient at the IMT Wellness Center, a goal list will help us recognize what you would like to accomplish. Your therapist will evaluate you with your input in mind. **"Patient Centered Goals"** will serve as the basis for treatment. Goals will be revised as needed.

**Please fill in the following so the therapist can consider your desires/goals.**

The following examples are provided to assist you with your response.

***I know I will be better when I can…***

Example 1. Walk independently for 15 minutes with no pain.
Example 2. Work using just a splint for a half day with occasional pain.
Example 3. Sit with the help of only one person for 30 seconds.
Example 4. Play 18 holes of golf without pain in my back.

**Please fill in the chart below, answering *"I know I will be better when I can…"***

1. _____
2. _____
3. _____
4. _____
5. _____


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