# 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 ____

If Child, Parent/Guardian's Name _____

Employer _____ Occupation _____

Address _____

Phone _____

In case of emergency, please provide us the name of the 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 insurance regardless of insurance coverage. I also understand that Dr. Giammatteo, D.Sci, DC, ND, PT, Ph.D., IMT-C, CCE is a non-participating Medicare provider.

Patient/Guardian Signature _____ Date _____

12 North Main Street, Suite 30, West Hartford, CT 06107 Telephone (860) 561 2286

# 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 recommended 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. _____

If a doctor referred you to our clinic, please list below. Is there anyone else you would like to send this report to? (CC below)

Give us their name and address: Additional CC: Name and Address:

_____ _____

_____ _____

_____ _____

_____ _____

Please report all current areas of pain and the usual range of pain
(0 no pain – 10 excruciating/debilitating pain)
Ranges of Pain - In column to the right of body part, put the number equaling pain
For example Head 4-7

| | | | | | |
|---|---|---|---|---|---|
| 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 indicate what makes your pain worse. Place a checkmark in the box beside activity if it makes 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: | |

_____

_____

What 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: _____

_____

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

At birth? _____ Date _____

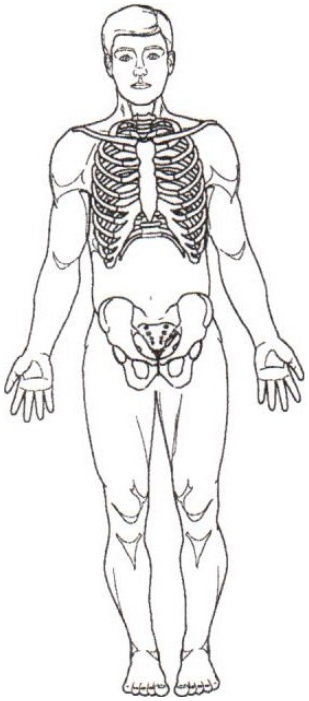
Was your onset of pain sudden? _____ Gradual? _____ Explain if necessary:

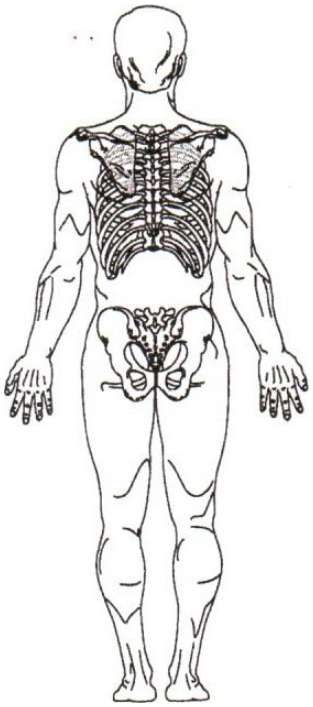
_____

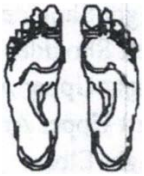
_____

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

**Front** **Back**







R L

**Right Side** **Left Side**

Therapist Please place this page in the patient's chart.

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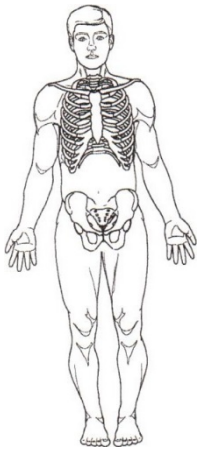
Paresthesia: Please check the following areas of “funny feeling” (tingling, burning, pins and needles, etc.)

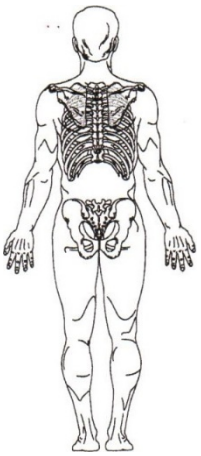
| | | | | | |
|---|---|---|---|---|---|
| | Head | | Right lower arm | | Right front thigh |
| | Face | | Left lower arm | | Left front thigh |
| | Jaw | | Right wrist | | Right back thigh |
| | Front of neck | | Left wrist | | Left back thigh |
| | Back of neck | | Right fingers | | Right knee |
| | 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 | | |

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

Front



Back



R L

Right Side

Left Side

Patient Name: _____

**Please tell us about your symptoms by checking the appropriate areas:**

| | Frequency | | | Severity | | |
|---|---|---|---|---|---|---|
| | **Occasional** | **Often** | **Constant** | **Mild** | **Moderate** | **Severe** |
| Dizziness, light headed | | | | | | |
| 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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**Function:** Activities of daily living 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: _____

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 spend 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 experience pain/disability problems: _____

_____

_____

**Current Assistive Devices:** Please check mark under either yes or no

| | 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

| | |
|---|---|
| Alcoholism | |
| Allergies | |
| Alzheimer's Disease | |
| Arthritis | |
| Asthma | |
| Attention Deficit Disorder (ADD) | |
| Attention Deficit Hyperactivity Disorder (ADHD) | |
| Autoimmune Disease | |
| Back pain | |
| Bronchitis | |
| Cancer/What Type | |
| Carpal Tunnel Syndrome | |
| Cerebral Palsy | |
| Elevated Cholesterol | |
| Chronic Fatigue Syndrome | |
| Circulatory Problems | |
| Colitis | |

Please continue filling in blanks where applicable

| | |
|---|---|
| Dental Problems | |
| Depression | |
| Diabetes | |
| Diverticular Disease | |
| Drug Addiction | |
| Eating Disorder | |
| Epilepsy | |
| Environmental Sensitivities | |
| Eyes, ears, nose, throat problems | |
| Facial Palsy | |
| Fibromyalgia | |
| Food intolerance | |
| Gastrointestinal | |
| Genetic Disorder | |
| Glaucoma | |
| Gout | |
| Headaches: Frequency?<br>Duration?<br>Intensity range 1-10? | |
| Heart Disease | |
| High Blood pressure | |
| Infection, Chronic (type) | |
| Inflammatory Bowel Disease | |
| Irritable Bowel Syndrome | |
| Kidney or Bladder disease | |
| Learning Disabilities | |
| Liver or Gallbladder Disease (stones) | |
| Lymphedema | |
| Lymphatic problems | |
| Mental Illness | |
| Mental Retardation | |
| Migraine Headaches: Frequency?<br>Duration:<br>Intensity/Range (0-10) | |
| Mononucleosis | |
| Multiple Sclerosis | |
| Musculoskeletal problems | |
| Obesity | |
| Osteoporosis | |
| Paraplegia | |
| Parkinson's | |
| Phobias | |
| Pneumonia | |
| Quadriplegia | |
| Respiratory problems | |
| Rheumatoid Arthritis | |

Please continue filling in blanks where applicable

| | |
|---|---|
| Seasonal Affective Disorder | |
| Sexually Transmitted Disease | |
| Sinus problems | |
| Skin Problems | |
| Spina bifida | |
| Stroke | |
| Thyroid problems | |
| Traumatic Brain Injury (TBI) | |
| Tuberculosis | |
| Ulcer | |
| Urinary Tract Infection | |
| Varicose Veins | |
| Other | |
| Other | |
| Other | |

Men:

| | |
|---|---|
| Benign Prostatic Hypertrophy | |
| Decreased Sex Drive | |
| Infertility | |
| Prostate Cancer | |
| Sexually Transmitted Disease | |
| Other | |
| Other | |

Women:

| | |
|---|---|
| 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 | |

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:
_____
_____
_____
_____
_____

What and when was your last vaccination/inoculation? _____
Did you become ill? Yes No

When have you traveled out of the country? _____
Did this require inoculation? Yes No
Did you become ill? Yes No

Are you losing weight without trying? Yes No

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

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

**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: Cigarettes #/day _____ Cigars #/day _____ Pipe _____ Chewing _____
Alcohol: Wine or beer #glasses/day or week _____ Liquor # ounces/day or week _____
Caffeine: Coffee: #6 oz. cups/day _____ Tea: #6 oz. cups/day _____
Soda with caffeine: #6 cans/day _____ Diet sodas #cans/day _____

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

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

**Nutrition and Diet** – Please check whichever is applicable.

| | |
|---|---|
| Vegetarian | |
| Vegan | |
| High Protein | |
| Salt Restriction | |
| Low Fat Diet | |
| Starch/Carbohydrate Restriction | |
| The Zone Diet | |
| Atkins Diet | |
| Other | |
| 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 the major causes of stress (changes in job, work, residence, finances, or legal problems

_____

_____

_____

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

| Names of those presently taking | Dosage | For how long? | List any meds or supplements you have taken in the past 5 years |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you seeing any doctors or health care professional now for any reason? Yes No
(Note: These practitioners will not be contacted without your permission)

Do you want us to send our evaluation notes to these practitioners? Yes No

| Practitioner's Name | Type of Practitioners | Phone number or address |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

While you are a patient here 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 to answer.

**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. _____