IMT Wellness Center

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, DC, D.Sci, ND, PT, Ph.D., IMT-C, CCE is a non-participating Medicare provider.

Patient/Guardian Signature _____ Date _____

Office Use: Reviewed _____ Date_____

IMT Wellness Center

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. _____

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

Office Use: Reviewed _____ Date_____

Patient Name/ Initials: _____

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?) _____

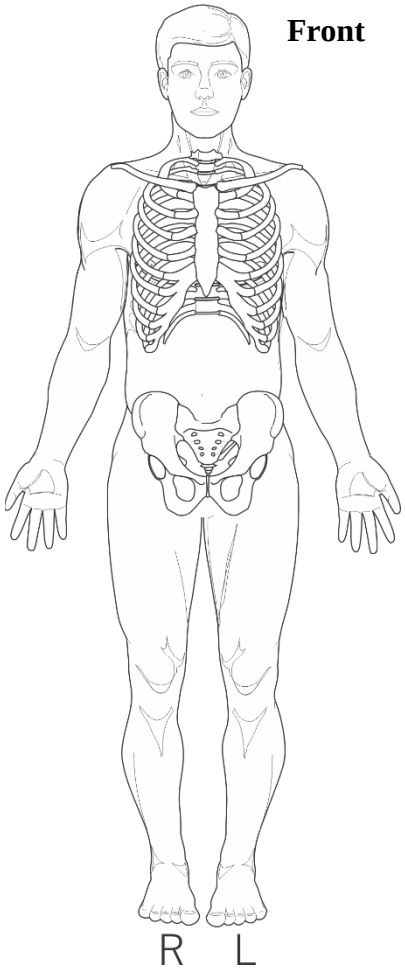
Was your onset of pain sudden? _____ Gradual? _____ Explain if necessary:

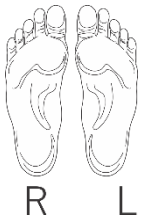
_____

Patient Name/ Initials: _____

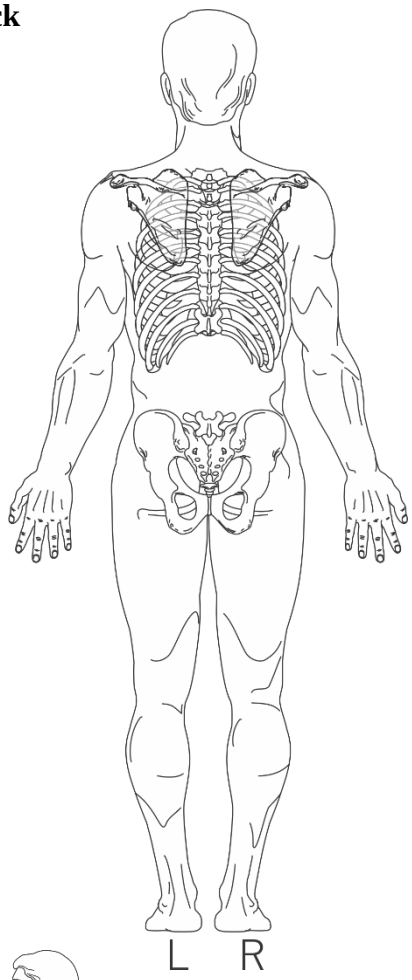
Pain Diagram: Please shade in all areas of pain. Be as thorough and specific as possible.

Front

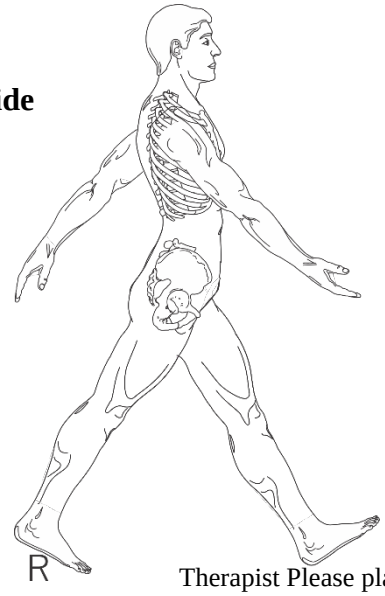




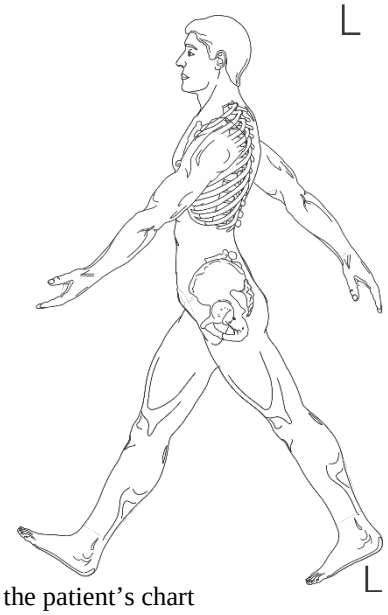
Back



Right Side



Left Side



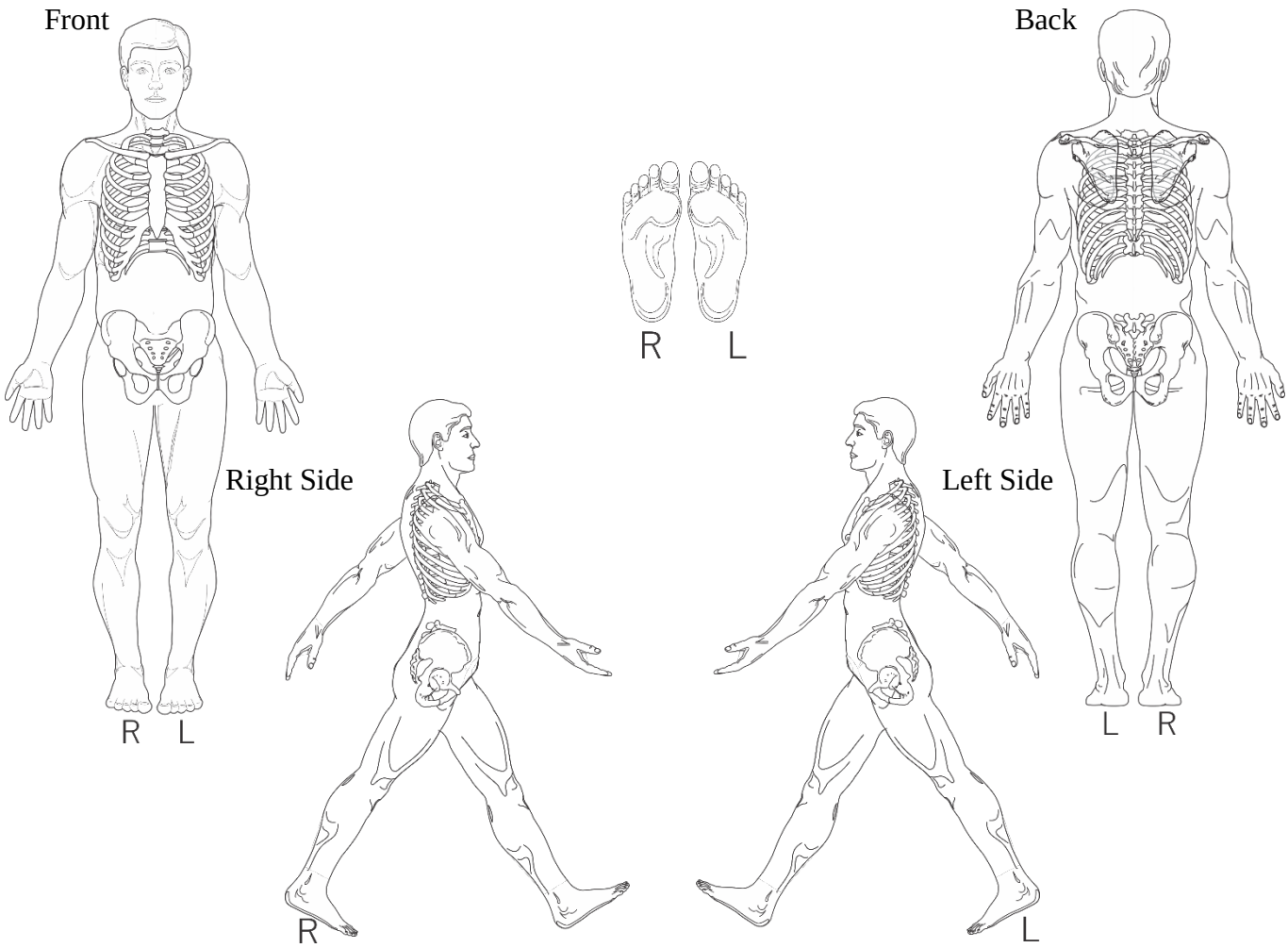
Therapist Please place this page in the patient's chart

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		

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



IMT Wellness Center

Patient Name/ Initials: _____

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						

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: _____

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 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: _____

_____

_____

Patient Name/ Initials: _____

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

	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			

Please continue filling in blanks where applicable Patient Name/ Initials:_____

	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			
Eyes, ears, nose, throat problems			
Facial Palsy			
Fibromyalgia			
Food intolerance			
Gastrointestinal			
Genetic Disorder			
Glaucoma			
Gout			
Headaches: Frequency? Duration/ Intensity1-10			
Heart Disease			
High Blood pressure			
Infection, Chronic (type)			
Inflammatory Bowel Disease			
Irritable Bowel Syndrome			
Kidney/Bladder disease			
Learning Disabilities			
Liver or Gallbladder Disease (stones)			
Lymphedema			
Lymphatic problems			
Lyme Disease			

Please continue filling in blanks where applicable Patient Name/ Initials:_____

	Date:	Treatment:	Resolved? (Y/N)
Mental Health Illness / Issue			
Mental Retardation			
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			

Please continue filling in blanks where applicable Patient Name/ Initials:_____

	Date:	Treatment:	Resolved? (Y/N)
Tattoos			
Thyroid Problems			
Traumatic History			
Traumatic Brain Injury (TBI)			
Tuberculosis			
Ulcer			
Urinary Tract Infection			
Varicose Veins			
Yeast Infection			
Other			
Other			
Other			

Men:

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

Women:

	Date(s):	Treatment:	Resolved? (Y/N)
Last OBGYN Appt		Pap? (Y/N) Mammo? (Y/N)	
Child Birth		C-Section? (Y/N)	
Breast Cancer			
Breast Surgery/Reduction/ Implants			
Decreased Sex Drive			
Endometriosis			
Fibrocystic Breasts			
Fibroids/Ovarian Cysts			
Infertility			
Menstrual irregularities			

Patient Name/ Initials: _____

	Date:	Treatment	Resolved? (Y/N)
Date of last menses			
Pelvic Inflammatory Disease			
PMS			
Sexually Transmitted Disease			
Vaginal Infections			
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?
Date: _____Name:_____
Did you become ill? Yes No

When/Where have you traveled out of the country?
Date:_____Destination:_____
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

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: Cigarettes #/day _____ Cigars #/day _____ Pipe _____ Chewing _____
Cannabis: THC or CBD Form of Intake:_____
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								

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

_____

_____

_____

Patient Name/ Initials: _____

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

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. _____