FULL RANGE HEALTH SERVICES®
Your Life. Your Goals. Your Way.

Tel: 610.241.2685
Fax: 877.732.7311
WWW.FULLRANGEHEALTH.ORG

Name: _____ **Date**: _____

Date of Birth: _____ Personal Email Address: _____

Primary Care Physician: _____ **Occupation:** _____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Please document your height and weight: Height: _____ Weight: _____

Reason for Today's Visit: _____

Is this a reoccurrence of a prior injury?

Yes ☐ No ☐ If yes, what year was the prior injury? _____

Is this a work-related injury?

☐ Yes ☐ No

Have you received surgery for this injury?

Yes ☐ No ☐ If yes, what was the date of your surgery? _____

Describe what type of pain you feel:

☐ Aching ☐ Dull ☐ Heavy ☐ Pins and needles
☐ Cramping ☐ Variable ☐ Burning ☐ Stabbing
☐ Weak ☐ Numb ☐ Deep ☐ Constant ☐ Throbbing

Rate your pain on a scale of 0-10 (0= no pain, 10= worst pain I have ever felt)

What was the level of your pain when the injury first occurred? _____
What is your pain: Currently: _____ At best: _____ At worst: _____

What makes your pain feel worse?

_____

What relieves your pain?

☐ Ice ☐ Lying flat ☐ Exercise ☐ Pain medication ☐ Stretching
☐ Nothing ☐ Heat ☐ Avoiding activity ☐ Rest

Medical History: Check each of the items that relate to your medical history:

☐ Anemia	☐ Pacemaker	☐ Allergies
☐ Back Pain	☐ Angina	☐ Asthma
☐ Bronchitis	☐ Blot clot/Emboli	☐ Bowel/bladder problems
☐ Coronary Heart Disease	☐ Drink Alcohol	☐ Dizziness or fainting
☐ Gout	☐ Emphysema	☐ Epilepsy/Seizures
☐ Hernia	☐ Hearing difficulties	☐ Heart attack
☐ Parkinson's	☐ High blood pressure	☐ Kidney Disease
☐ Severe/frequent headaches	☐ Pneumonia	☐ Pregnant
☐ Stroke/TA	☐ Sleeping problems	☐ Cigarettes/Other Tob Use
☐ Vision difficulties	☐ Thyroid problems	☐ Varicose Veins
☐ Women's health issues	☐ Weakness	☐ Weight loss/energy loss
☐ Cancer: _____	☐ Diabetes: Type 1 ☐ Type 2 ☐	

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Medical History: Check each of the topics that relate to your medical history.

- ☐ Joint replacement — If yes, location: _____
- ☐ Arthritis — If yes, location: _____
- ☐ Pins or metal implant — If yes, location: _____
- ☐ Numbness/tingling/neuropathy — If yes, location: _____

Medical History: Circle each of the topics that relate to your medical history.

I use the following equipment: ☐ cane ☐ walker ☐ wheelchair ☐ Other: _____

☐ I live alone ☐ I received nursing at home ☐ I received P.T.

☐ I am caregiver for someone else ☐ Other important issues: _____

Does your diagnosis impact your ability to do your job?

- ☐ I am retired
- ☐ I can only work part time
- ☐ I can work, but with minor difficulty
- ☐ Not applicable
- ☐ The diagnosis prevents me from working.
- ☐ I can work, but with great difficulty.
- ☐ The diagnosis does not impact my ability to work.

Please list current medications, including dosage and route: *Ex: Tylenol 2 tabs 325 every 6 hrs as needed orally.

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

ALLERGIES: _____

Are you latex sensitive? Yes ☐ No ☐

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

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

How Did You Hear About Us?

☐ Doctor ☐ Family/Friend ☐ Online ☐ Social Media ☐ Other

Patient Signature _____ **Date**: _____

(For Office Use Only)

Clinician Initials: _____ **Date:** _____