103 Roxbury Street
Suite 200C
Keene, NH 03431
Info@monadnockmfr.com
phone 603-355-6637
fax 603-355-6632

Initial Evaluation Client History Form

Date:_______________

Name: ____

What is your preferred Pronoun:____

If minor parent name/'s____

Street address: ____

Town: ________________ State: ________ Zip Code: ______________

Phone numbers: home____________________cell______________________work_________________________

E mail addresses:____

Date of Birth: _____________

Emergency Contact Name_____________________ Phone______________ Relationship to you_______________

Physician's name and phone number: ____

Date of last MD visit:________________

Are you currently working? ____________ What is your occupation? ___________________________________

How did you hear about us? ____

1. What is the **primary issue** that brings you here?

Secondary complaint?

2. **When** did your symptoms begin? ____

3. **How** did your symptoms begin? For example, did your symptoms begin because of an accident or trauma, or did they begin without a known cause?

4. On the lines below, place a slash mark to indicate your **functional ability** as a % of normal.

On a good day 0%____100%

On a bad day 0%____100%

5. Put a slash mark on the line below to rate the **INTENSITY** of your symptoms within the last 3 days.
No pain ____Worst pain imaginable
0% 100%

Put a slash mark on the line below to rate the **FREQUENCY** of your symptoms within the last 3 days.
No pain ____Constant pain
0% 100%

Put a slash mark to indicate your **ENERGY LEVEL** on an average day.
No energy ____ Lots of energy
0% 100%

6. What activities INCREASE your symptoms?

7. What activities DECREASE your symptoms?

8. List any **OTHER MODALITIES OR THERAPIES** you've tried for this condition and describe their effectiveness:

9. Are you currently receiving OT or PT anywhere else this at this time? Y / N
   9a. If Yes, please provide which service, how many visits you have had, and what you are being treated for:

10. **PAST MEDICAL HISTORY**: Please list all your surgeries, traumas, accidents, or other conditions, and the years they occurred.

11. Are you currently pregnant or is there a possibility you may be pregnant? Y / N

12. Please list all current **MEDICATIONS AND SUPPLEMENTS** as well as dosage and reason for taking them use the back of this page as necessary:

13. Please rate on a scale of 1-10 how much emotional stress your symptoms or condition have caused you, with 1 being very little, to 10 being the worst you can imagine.

14. List your **TREATMENT GOALS**, and be as specific as possible (ie. I want to walk to work and back without pain.)

15. We are honored and excited that you've chosen to work with us. We take pride in creating an atmosphere of trust, safety, and openness during the treatment process. As well, we create a dynamic partnership with our clients, and its' mission is to meet your goals for treatment. Please don't hesitate to ask any questions, and provide us with feedback about how things are going for you.

By signing here, you agree to understand the following:

- Bringing shorts for men, or shorts and a work out bra for women to change into for the session is ideal. We need to see your body to assess your alignment, and have as much access to your skin as possible for treatment.
- There may be some residual soreness and emotional releases following the treatment session. Drinking lots of water, taking warm baths or applying heat will help, and it should resolve within a few days. I will let my therapist know about this, and ask any questions I need to for support.
- I will let my therapist know of any changes in my medical condition or medication schedule.
- This is a treatment program, and to get the most benefit from it as possible, receiving treatment 1-3 times per week as recommended by my therapist as well as following the home exercise program is best.
- I have read and understand my insurance coverage, the HIPAA policy, and the cancellation policy for this practice.
- If my insurance company is not being billed my payment is expected at the time of service using cash, visa/mc or check, and any returned checks will be assessed a $30 fee.
- I will pay for any services, percentages and fees deemed necessary to collect any of my unpaid invoices

Signature:____ Date:______________________________