



"Excellence In Motion"

50 Coxe Avenue, Asheville, NC 28801
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Symptomatic Patient Intake

Date: ___/___/___ Patient's Full Name: _____
Address: _____ City: _____ State: ___ Zip: _____ Date of Birth: _____
Phone: _____ E-Mail: _____ Male Female Age: ___

Chief Complaint

What hurts? _____

Secondary or related complaint(s) if any: _____

Was the Onset: Gradual or Sudden

When did it first occur? _____

Since the onset, has it gotten: Better or Worse

Has this occurred before?

Yes No (If Yes, #of times: ___)

Describe what caused the pain: _____

Pain Scale – How much does it hurt?

0 1 2 3 4 5 6 7 8 9 10

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No pain

Moderate

Severe

What does your condition prevent you from normally doing? sitting/driving walking running
 golfing swimming weight lifting playing with children normal activities of daily living other: _____

What is your long-term goal from treatment (e.g. play a round of golf without pain)? _____

Please list any major illnesses, injuries, hospitalizations, accidents, or surgeries.

Date	Injury/ /Illness/Surgery	Treatment	Results

What medications are you currently taking?

What vitamins/supplements are you currently taking?

Please indicate any of the following illnesses you have had or currently have with approximate dates.

- Allergies _____
- Auto accident _____
- Cancer _____
- Depression _____ Were you treated with medication? _____
- Diabetes _____
- Eating disorders _____
- Heart disease _____
- High Blood Pressure ____ Do you take Statin medication? ____ Dosage/Duration? _____
- HIV/AIDS _____
- Kidney disease _____
- Mental/Emotional _____
- Multiple Sclerosis _____
- Prostate disease _____
- Scoliosis _____
- Serious injury/fall _____
- Seizures _____
- Stroke _____
- Ulcer _____
- Venereal Disease _____
- Other _____

Manual therapy and rehabilitative exercise contain the inherent risk of sprain, strain, fracture and dislocation. By signing below you acknowledge under no duress that you understand and accept this risk.

Signed (Parent or legal guardian if under 18 years of age) _____ Date _____

The Stay Active Clinic is an open setting. This means your rehabilitative exercise and manual therapy are performed in the open while being visible to others. All care is taken to be discrete and you are free to request a private setting whenever you wish. By signing below you acknowledge and accept the statements above.

Signed (Parent or legal guardian if under 18 years of age) _____ Date _____