Creekside Wellness Center
2730 Longmire Drive, Suite B
College Station, TX 77845
Fax: (979) 977-5670

linda@motionforhealth.com
(979) 314-5933

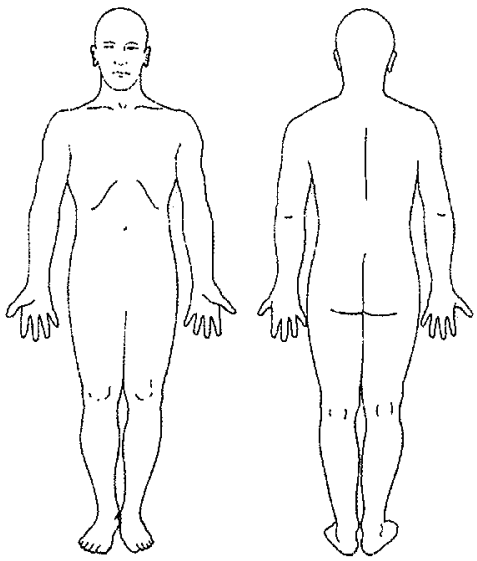
New Patient Information Sheet

Welcome to our practice! Please help us serve you better by taking a few minutes to provide the following information:

Name:			Date:
Address:			
City/ST/Zip			
Phone Numbers	Mobile:	Home:	Work:
Date of Birth		Age:	Marital Status ☐ M ☐ S ☐ W ☐ D
Email			
Occupation			
Emergency Contact	Name:	Phone:	
Primary Care Physician	Name:	Phone:	
	Date of Next Visit:		
Specialist Physician	Name:	Phone:	
	Specialty:	Date of Next Visit:	
Specialist Physician	Name:	Phone:	
	Specialty:	Date of Next Visit:	
Specialist Physician	Name:	Phone:	
	Specialty:	Date of Next Visit:	

How did you hear about our practice?	
Who can we thank for referring you to our practice?	

The following information on these next pages is very important in our evaluation process. Please complete as specifically as possible to provide us with a clear picture of your present symptoms, pain, challenges, and functional status.

What is the primary issue that brings you in today?	**Please shade in areas where you have pain, discomfort, or tension** 
Do you have any secondary concerns or problems?	
Because of these problems, what are you now having difficulty with?	
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like?	
When did your symptoms begin? (Date)	

Please rate your pain:

Rate your pain in the last 24-72 hours using the 0-10 scale, where 0 is no pain, and 10 is the worst possible pain.		**NO PAIN = 0. WORST PAIN = 10**
	At its worst	
	At its best	
	At present	
	At night (sleeping)	
At what time of day are your symptoms the worst?		
At what time of day are your symptoms the best?		
What activities increase your pain?		
What activities decrease your pain?		

What other types of treatment have you had for this problem? (Please check all that apply.)

- ☐ Massage
- ☐ Bodywork
- ☐ Physical Therapy
- ☐ Myofascial Release
- ☐ Chiropractic
- ☐ Surgery

What other medical conditions have you had or have now?

- ☐ Diabetes
- ☐ Lung Disease
- ☐ Weight Change
- ☐ Varicose Veins
- ☐ Neurological Problems
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Osteoporosis
- ☐ Migraine Headaches
- ☐ Epilepsy/Seizures
- ☐ Stroke
- ☐ Blackouts
- ☐ Heart Murmur
- ☐ Malignancy
- ☐ Arthritis
- ☐ Broken Bones (Fracture)
- ☐ Metal Implants
- ☐ High Blood Pressure
- ☐ Circulatory Problems
- ☐ Liver Disease
- ☐ Heart Disease/Pacemaker
- ☐ Kidney Disease

- ☐ Other (Please describe)

List past medical history and dates of occurrence. Include surgeries, accidents, and other traumas.

Date:
Description:
Date:
Description
Date :
Description:
Date :
Description:
Date :
Description:

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. Please include non-prescription supplements, vitamins, and herbal and homeopathic remedies.

Medication	For Treatment Of	Dose/Amount per Day	Effectiveness

Do you smoke currently?	☐ Yes ☐ No
	If "Yes", how many cigarettes per day? _____ If "Yes", would you like to quit? ☐ Yes ☐ No
Have you smoked in the past and quit?	☐ Yes ☐ No
	If "Yes", how many cigarettes per day? _____ If "Yes", how many years did you smoke? _____ If "Yes", when did you quit? (MM/DD/YEAR) ____/____/_____

Is there a chance you may be pregnant at this time?	☐ Yes ☐ No

Do you engage in regular exercise?	☐ Yes ☐ No	
If "Yes", what type of exercise:		
		How often? ____ X a Week
		How often? ____ X a Week
		How often? ____ X a Week
		How often? ____ X a Week
Are you able to exercise now?	☐ Yes ☐ No	

Do you have discomfort, shortness of breath, or pain with exercise?	☐ Yes ☐ No
If "Yes", please describe:	
In general, how would you rate your lifestyle?	☐ Very Active ☐ Somewhat Active ☐ Average ☐ Somewhat Inactive ☐ Inactive

If sleep is a problem, please answer these questions:

Do you have trouble falling asleep?	☐ Yes ☐ No
Is your sleep restful?	☐ Yes ☐ No
Do find it difficult to lie down?	☐ Yes ☐ No
Do you find it difficult to change positions in bed?	☐ Yes ☐ No
How many times do you wake in the night?	_____
How long before you fall back asleep?	_____

List all the tasks/activities that you want to do but have difficulty performing, and your tolerance (in minutes/hours) or if you can no longer perform them.

Task/Activity	How many Minutes/Hours can you tolerate	Can no longer perform
		☐
		☐
		☐
		☐
		☐
		☐

I walk for _____ minutes before needing to rest	
I stand for _____ minutes before needing to sit	
I sit for _____ minutes before needing to change positions/get up	
Do you have trouble getting up from a chair?	☐ Yes ☐ No
Do you have trouble putting on your shoes and socks?	☐ Yes ☐ No
Do you have difficulty climbing stairs	☐ Yes ☐ No

YOUR GOALS
Please list all the tasks/activities that you would like to do as a result of therapy.

Task/Activity	Duration/How Often	By When

Informed Consent

I understand that Motion For Health will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment.

Photographs taken during initial evaluation, progress evaluation, and discharge summary will be used for postural comparison purposes and as educational tools. By signing below, I consent to the use of these photographs in a professional manner.

I do hereby agree and give my consent for Motion For Health to furnish care and treatment that is considered necessary and proper in the diagnosing or treating of my physical condition.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I hereby certify that all the above information is true to the best of my knowledge:

Patient/Parent/Guardian Name: _____

Signature: _____

Date: _____