Liberty Hospital
Liberty, MO 64068

Patient Label Here

Thank you for choosing Liberty Hospital.
Please take your time answering the following questions as it will help us give you the best care possible.

CURRENT CONDITION:

Referring Physician: _____ Primary Care Physician: _____

Date of injury/surgery: _____ Mechanism of injury: _____

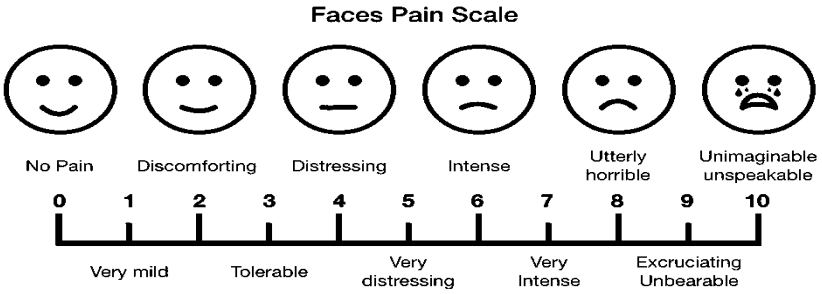
Describe your chief complaint / concern: _____

Identify any position / activity that eases your symptoms: _____

Identify any position / activity that aggravates your symptoms: _____

Please rate your pain:

At best: _____
At worst: _____
Average: _____
Current: _____



Previous interventions prior to therapy? (chiropractic care, pain meds, etc) _____

Have you received any imaging (x-ray, MRI, etc): _____

Do you exercise beyond normal activites and chores? If so, please describe activities and how often you perform them:

_____

Are you currently working? If yes, please list occupation: _____

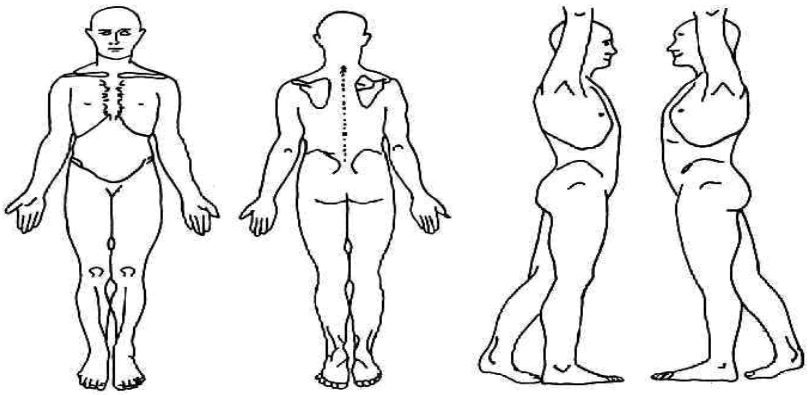
Has your work status changed as a result of this injury? ☐ Yes ☐ No

If currently off of work due to injury, what is your anticipated date of return? _____

Have you fallen in the past 12 months? ☐ Yes ☐ No How many times? _____

What is your goal with therapy: _____

Please mark areas where you feel symptoms on the chart below:



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Previous surgeries and the date	Current **prescribed** and **non-prescribed** medication See attached list: ☐	**Allergies** Are you allergic to latex/rubber? ☐ Yes ☐ No

Medical History

- ☐ Alcohol/substance abuse
- ☐ Alzheimer's disease/dementia
- ☐ Anemia
- ☐ Anxiety/depression
- ☐ Autoimmune Disorder _____
- ☐ Cancer _____
- ☐ Currently pregnant # weeks _____
- ☐ Diabetes: Type 1 or Type 2
- ☐ Dizziness or vertigo
- ☐ Fall resulting in injury (in past year)
- ☐ Fibromyalgia
- ☐ Fractures - site _____
- ☐ Headaches/migraines
- ☐ Hearing loss/problems
- ☐ Heart Condition (list below) _____
- ☐ High blood pressure
- ☐ History of abuse(physical/sexual)
- ☐ Joint replacement (list location) _____
- ☐ Latex sensitivity
- ☐ Leaking of urine or stool
- ☐ Lymphedema
- ☐ Lung conditions/asthma
- ☐ Memory problems
- ☐ Multiple sclerosis
- ☐ Neuromuscular disorder
- ☐ Neuropathy
- ☐ Osteoarthritis (list locations) _____
- ☐ Osteoporosis/osteopenia
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Psychiatric disorder _____
- ☐ Postpartum depression
- ☐ PTSD
- ☐ Rheumatoid arthritis
- ☐ Scoliosis
- ☐ Seizures/Epilepsy
- ☐ Smoker
- ☐ Stroke/TIA
- ☐ Thyroid disorder
- ☐ Traumatic brain injury
- ☐ Vision/eye problems
- ☐ Other _____ _____

Do you have an Advance Directive (e.g. living will, durable power of attorney, or any other written instructions regarding your health care treatment decisions? ☐ Yes ☐ No

If ***Yes***, is it current?

☐ Yes. Where? ☐ In your possession ☐ On file with Liberty Hospital ☐ Other:

☐ No. Would you like for Liberty Hospital's Social Services Department to perform a consultation over the telephone? ☐ Yes ☐ No

Patient Signature	Date	Time
Therapist Signature	Date	Time
Therapist Signature	Date	Time
Therapist Signature	Date	Time

Reviewed/Updated	Date/Time