ICT MUSCLE & JOINT CLINIC
Move HEALTHY. Feel HEALTHY. Live HEALTHY.

Patient Information

ICT Muscle & Joint Clinic Ph: (316) 854-3010
7829 E. Rockhill St #303 Fx: (316) 854-1029
Wichita, KS 67206 www.ictmjc.com

Date: _____/_____/_____

Patient's Full Name: _____ Preferred Name (nickname)_____
Mailing Address: _____ City: _____State: ____ Zip: _____
Preferred Phone #: _____ Alternate Phone #: _____ E-Mail: _____
Date of Birth: ____/____/_____ □ Male □ Female Do you have a spouse? _____ Do you have children? _____
How were you referred to our office? Please be specific: _____
Occupation: _____ Employer: _____ Employer City: _____
What is your *long-term goal with treatment*? (E.g. run a 5k, play a round of golf, play with your kids, work without pain)
_____

Is today's visit due To a Work-Related Injury? □ Yes □ No
Is today's visit due To an Auto Accident? □ Yes □ No
****If answered yes to either question above, please check with staff member, additional information is needed

Current Health History:

Main complaint that has brought you in (one only):_____
Secondary or related complaint(s), if any: _____

SYMPTOM DIAGRAM & SEVERITY SCALE

*Please **mark your area(s) of pain** using the symbols below, then **name the area** & **mark its severity** on each scale to the left

+++ Burning XXX Dull/Ache /// Numbness/Tingling === Throbbing 000 Stabbing/Sharp

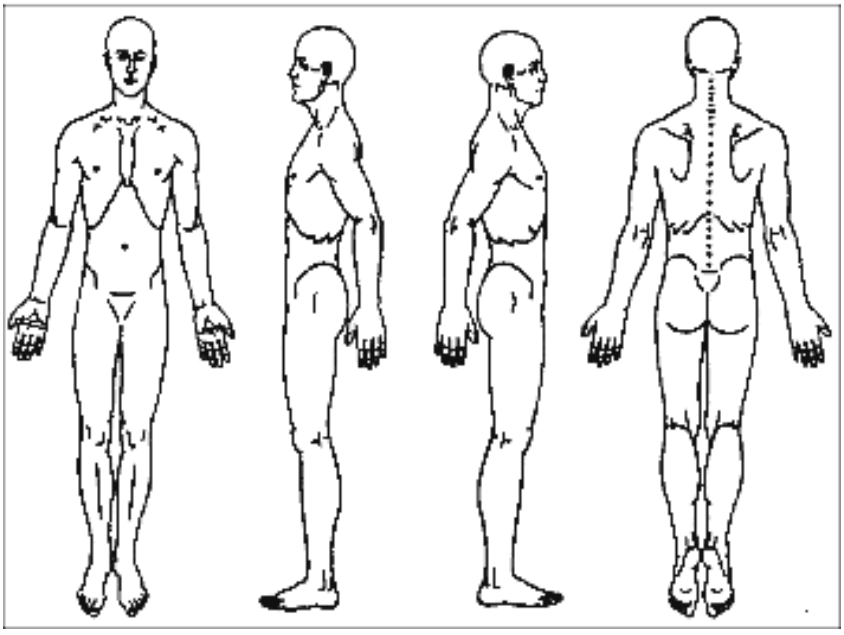
(0 = no pain 10 = worst possible)

SEVERITY OF PAIN/SYMPTOMS

1st Complaint _____
0 1 2 3 4 5 6 7 8 9 10

2nd Complaint _____
0 1 2 3 4 5 6 7 8 9 1 0

3rd Complaint _____
0 1 2 3 4 5 6 7 8 9 1 0



ICT Muscle & Joint Clinic
Move HEALTHY. Feel HEALTHY. Live HEALTHY.

Patient Information

ICT Muscle & Joint Clinic Ph: (316) 854-3010
7829 E. Rockhill St #303 Fx: (316) 854-1029
Wichita, KS 67206 www.ictmjc.com

Current health history continued:

Describe what caused the pain (if you know):_____
When did your symptoms begin? _____ The pain started: □ Gradually □ Suddenly □ Traumatic
Since it started, has it gotten: □ Worse □ Better □ Stayed the same
What makes your current condition(s) better?_____
What makes your current condition(s) worse? _____
Does the pain/complaint radiate or travel from one part of your body to another? Where? _____
Are your symptoms worse during a particular part of the day/night? _____
Have you detected any possible relationship of your current complaint with any of the following: □ Yes □ No
If yes, check: □ Bowel/Bladder □ Nausea □ Cardiac/Respiratory □ Other:_____
Have you tried any medication (over the counter or prescription)? □ Yes □ No
If yes, what:_____ Results:_____
Which other medications are you currently taking? _____
Have you ever experienced your present problem for which you are consulting us, before? □ Yes □ No
If yes, When? _____ Was treatment provided? □ Yes □ No
By whom?_____ Outcome?_____
Recreational Activities (Hobbies):_____
Do you exercise? _____ Do you smoke? _____ How many hours of sleep do you normally get? _____
How would you rate your current eating habits: □ Multiple servings of vegetables daily □ Some fruits & veggies daily
□ Very few/No vegetables daily Are you interested in changing your eating habits? □ Yes, very □ Maybe □ No
How much water do you drink per day? _____ Do you drink coffee, soda, or tea regularly? (Circle which apply)
Is work stressful to you? _____ Is family life stressful to you? _____
Have you ever had a stroke or issues with blood clotting? □ Yes □ No If yes, when? _____
Are you currently taking anti-coagulant or blood thinning medication? □ Yes □ No
Have you recently experienced dizziness, unexplained fatigue, weight loss, or blood loss? □ Yes □ No
Have you ever had any injuries, broken bones, hospitalizations, or surgeries in the area of complaint? □ Yes □ No
Do you have any other illnesses or medical issues that you feel the doctor should be aware of? _____
Do you have a family hisotry of any of the following? □ Diabetes □ Heart Disease □ Cancer
Do you ever have jaw pain or ever been told you clinch/grind your teeth? _____
Who is your primary care physician? _____ PCP Office _____
May we contact him/her? _____ ***We like to communicate our care with your PCP if possible***
Are you currently pregnant*? □ N/A □ Yes □ No *Who is your current OBGYN/Mid-Wife/Doula? _____