THE CENTER FOR MANUAL MEDICINE
&
REGENERATIVE ORTHOPEDICS

"We help you, help yourself"

Doug Frye MD,RMSK– Regenerative Orthopedics
Dani D. Steffen, DC–Chiropractic
C. Matt Elniff PT, FAAOMPT– Physical Therapy
Courtney Simon PT–Physical Therapy
Seth Harrison, CSCS- Clinic Manager

5000 SW 21ST STREET
TOPEKA, KS 66604
PHONE: 785-271-8100
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WEBSITE: www.ctrmm.com

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Name:_____

Preferred Name/Nickname: _____

What is your main complaint today?_____

_____

Date current problem started: _____

Medications or treatments for this condition:

_____

Are you experiencing any other joint pain today?

Yes No

Explain: _____

Do you have a durable power of attorney? Yes No

DOB: _____ Today's Date:_____

Primary Care Physician:_____

Occupation: _____

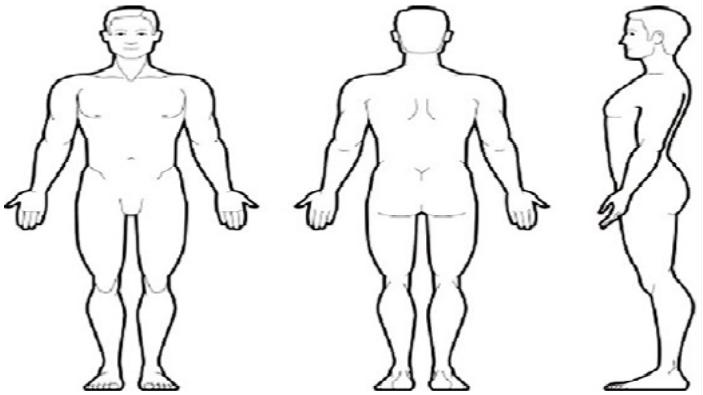
Is today's visit due to work or motor vehicle accident? Yes No

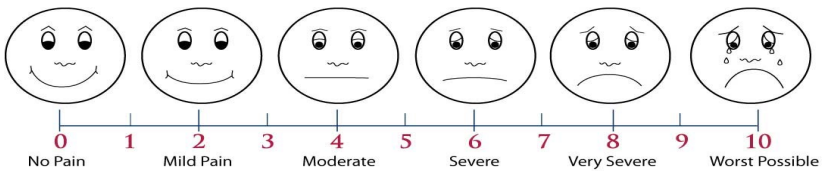
Explain: _____

Have you had any recent diagnostic studies (imaging) done for THIS issue

Type:	Yes	No	Date Taken:	Where were they taken?
X-ray	Yes	No	_____	_____
MRI	Yes	No	_____	_____
CT Scan	Yes	No	_____	_____
EMG	Yes	No	_____	_____

Mark the area of your body on the diagram where you are experiencing pain or discomfort.





Please rate your pain Today AND at its worst.

Circle YES or NO if **YOU** have any of the following conditions?

Yes No History of Cancer? Type: _____

Yes No Have Diabetes? Last A1C: _____

Yes No Past/Current use of cortisone or prednisone?

Yes No Osteoporosis/Osteopenia?

Yes No Urinary Issues? Elaborate :_____

Yes No Recent Fever?

Yes No Gastro-Intestinal Issues? Elaborate :_____

Yes No Unexplainable Weight Loss/Gain?

Yes No Heart Condition? Elaborate : _____

Yes No High Blood Pressure?

Yes No Epilepsy?

Yes No History of stroke? Type and Date (s):_____

Yes No Currently use tobacco products (Circle all that apply)

Vape Cigarettes Smokeless (Chew)

Amount: _____ How Long?_____

Yes No History of tobacco products?

Year quit:_____

Yes No History of Drug/Alcohol abuse?

Yes No Are you pregnant or nursing? Due Date: _____

Yes No History of breathing issues or Lung Disease?

Elaborate: _____

Yes No Depression/Anxiety/Psychiatric History/ PTSD?

Yes No Have you fallen in the last 3 months?

Yes No Were you injured? Elaborate: _____

Yes No Do you have an Autoimmune Disorder?

Elaborate: _____

FOR OFFICE USE ONLY:

Height:	BP:
Weight:	Pulse:

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Name:_____ **DOB:**_____ **Todays Date:**_____

Medication/Dosage:	Medication/Dosage:	Surgery/ Date of Surgery:	Surgery/Date of Surgery:

Allergies: _____

Do you have an ACTIVE infection? If so, please explain? _____

Have you ever had a staph infection, MRSA, or any other major infection? If so, please explain? _____

When was your last Flu Shot? _____ Have you had the pneumonia shot? Yes No Date:_____

Covid-19 Shot? Yes No Date:_____ Type:_____

Family History: (Please circle all that apply for family Member)

Father: Living Age:_____ Deceased Age: _____
Cause of death or current health conditions if applicable: Please Circle

Stroke/ Heart Condition Hypertension Diabetes Cancer:_____ (Type)
Autoimmune/Rheumatologic Disease Other COD: _____

Mother: Living Age:_____ Deceased Age: _____
Cause of death or current health conditions if applicable: Please Circle

Stroke/ Heart Condition Hypertension Diabetes Cancer:_____ (Type)
Autoimmune/Rheumatologic Disease Other COD: _____

Sibling 1: Living Age:_____ Deceased Age: _____
Cause of death or current health conditions if applicable: Please Circle

Stroke/ Heart Condition Hypertension Diabetes Cancer:_____ (Type)
Autoimmune/Rheumatologic Disease Other COD: _____

Sibling 2: Living Age:_____ Deceased Age: _____
Cause of death or current health conditions if applicable: Please Circle

Stroke/ Heart Condition Hypertension Diabetes Cancer:_____ (Type)
Autoimmune/Rheumatologic Disease Other COD: _____

Sibling 3: Living Age:_____ Deceased Age: _____
Cause of death or current health conditions if applicable: Please Circle

Stroke/ Heart Condition Hypertension Diabetes Cancer:_____ (Type)
Autoimmune/Rheumatologic Disease Other COD: _____