THE CENTER FOR MANUAL MEDICINE
&
REGENERATIVE ORTHOPEDICS

"We help you, help yourself"

5000 SW 21st Street Topeka, KS 66604 Phone: 785-271-8100 Fax: 785-271-9257 ctrmm.com

Name:_____

Preferred Name/Nickname: _____

What is your main complaint today?_____

_____

_____

Date current problem started:

_____

Medications or treatments for this condition:

_____

_____

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	_____	_____

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

Yes No Are you experiencing any other joint pain today?

Explain: _____

Yes No Do you have a durable power of attorney?

Yes No Do you want access to patient portal?

Yes No Unexplainable Weight Loss/Gain?

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?

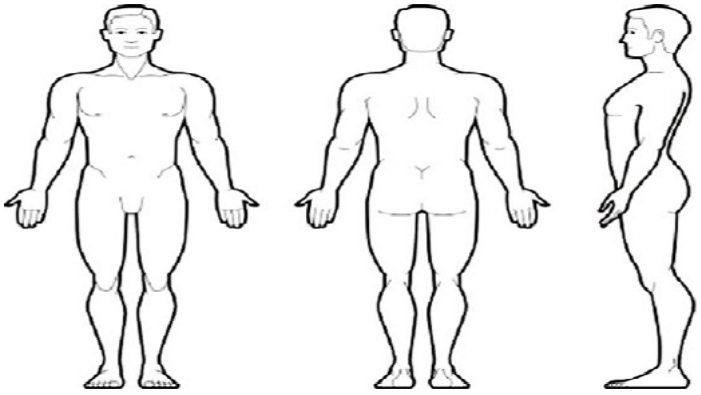
Yes No Are you pregnant or nursing? Due Date: _____

Yes No Have you fallen in the last 3 months?

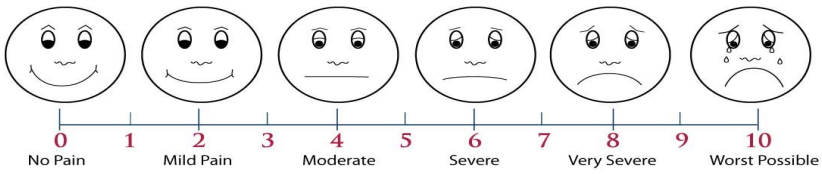
Yes No Were you injured? Elabrate:_____

_____

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.



In Office use:

Height:_____ Wt:_____

B/P_____ Pulse:_____

Turn over to fill out backside

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Name:_____ DOB:_____ Todays Date:_____

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

Allergies:_____

Allergic Reaction:_____

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:_____
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:_____
Autoimmune/Rheumatologic Disease Other COD: _____

Sibling 1: Living Age:_____ Deceased Age: _____ M / F
Cause of death or current health conditions if applicable: **Please Circle**
Stroke/ Heart Condition Hypertension Diabetes Cancer:_____
Autoimmune/Rheumatologic Disease Other COD: _____

Sibling 2: Living Age:_____ Deceased Age: _____ M / F
Cause of death or current health conditions if applicable: **Please Circle**
Stroke/ Heart Condition Hypertension Diabetes Cancer:_____
Autoimmune/Rheumatologic Disease Other COD: _____

Sibling 3: Living Age:_____ Deceased Age: _____ M / F
Cause of death or current health conditions if applicable: **Please Circle**
Stroke/ Heart Condition Hypertension Diabetes Cancer:_____
Autoimmune/Rheumatologic Disease Other COD: _____

Any other family history of cancer: Y / N Type:_____