Patient Name: ______________________

IMT Intake Form

Please tell us about your symptoms by checking the appropriate areas:

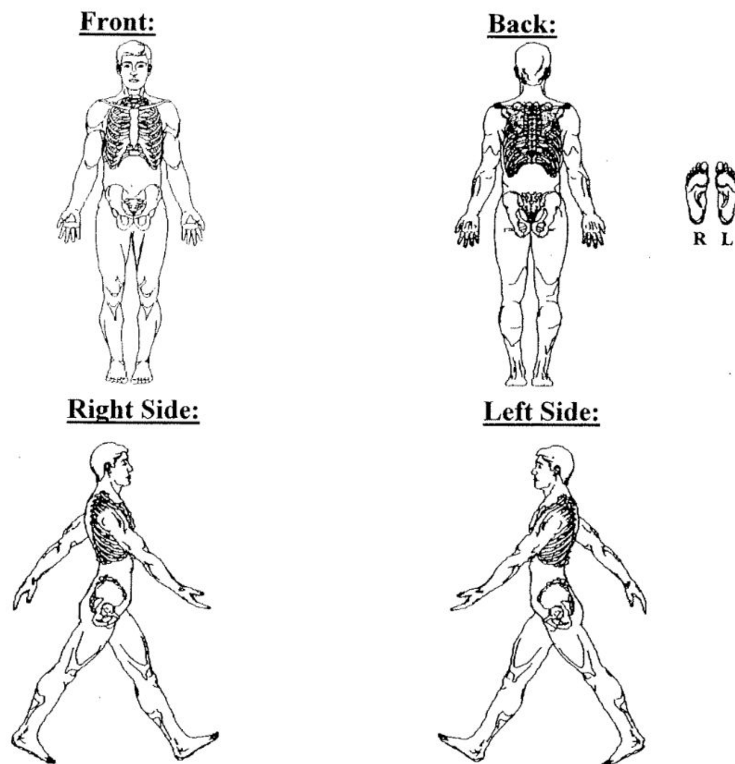
	FREQUENCY			SEVERITY		
	Occasional	**Often**	**Constant**	**Mild**	**Moderate**	**Severe**
Dizziness, light-headedness	▢	▢	▢	▢	▢	▢
Pass out easily (faint)	▢	▢	▢	▢	▢	▢
Decreased concentration/attention	▢	▢	▢	▢	▢	▢
Short term memory loss	▢	▢	▢	▢	▢	▢
Slurred speech	▢	▢	▢	▢	▢	▢
Balance or coordination problems	▢	▢	▢	▢	▢	▢
Headaches	▢	▢	▢	▢	▢	▢
Nausea	▢	▢	▢	▢	▢	▢
Indigestion	▢	▢	▢	▢	▢	▢
Difficulty swallowing	▢	▢	▢	▢	▢	▢
Ears: ringing, stuffy, painful	▢	▢	▢	▢	▢	▢
Vision: blurring, burning, aching, pressure, change, double	▢	▢	▢	▢	▢	▢
Drooping eyelid or any changes in your pupils	▢	▢	▢	▢	▢	▢
Allergies	▢	▢	▢	▢	▢	▢
Sinus problems	▢	▢	▢	▢	▢	▢
Nagging cough, hoarseness	▢	▢	▢	▢	▢	▢
Chest pain	▢	▢	▢	▢	▢	▢
Cold hands	▢	▢	▢	▢	▢	▢
Cold feet	▢	▢	▢	▢	▢	▢
Stiffness	▢	▢	▢	▢	▢	▢
Bowel problems	▢	▢	▢	▢	▢	▢
Unusual bleeding or discharge	▢	▢	▢	▢	▢	▢
Sexual function problems	▢	▢	▢	▢	▢	▢
Change in any wart or mole	▢	▢	▢	▢	▢	▢
Sore that does not heal	▢	▢	▢	▢	▢	▢
Thickening in your breast/elsewhere	▢	▢	▢	▢	▢	▢
Snoring	▢	▢	▢	▢	▢	▢
Pain that wakes you from a sound sleep	▢	▢	▢	▢	▢	▢
Night sweats	▢	▢	▢	▢	▢	▢

Patient Name: ______________________

Paresthesia: Please check the following areas of "funny feeling" (tingling, burning, pins and needles, etc.)

▢ Head	▢ Face	▢ Jaw	▢ Front of neck
▢ Back of neck	▢ Right side of neck	▢ Left side of neck	▢ Right shoulder
▢ Left shoulder	▢ Right upper arm	▢ Left upper arm	▢ Right elbow
▢ Left elbow	▢ Right lower arm	▢ Left lower arm	▢ Right wrist
▢ Left wrist	▢ Right fingers	▢ Left fingers	▢ Upper back
▢ Chest/rib cage	▢ Abdomen	▢ Lower back	▢ Buttocks
▢ Right hip	▢ Left hip	▢ Right front thigh	▢ Left front thigh
▢ Right back thigh	▢ Left back thigh	▢ Right knee	▢ Left knee
▢ Right shin	▢ Left shin	▢ Right foot	▢ Left foot
▢ _____________	▢ _____________	▢ _____________	▢ _____________

Paresthesia Diagram: Please shade in all areas of "funny feeling" (tingling, burning, pins and needles, etc.)



Patient Name: ______________________

How many hours do you sleep at night?

____

How many hours per day (24 hours) do you spend in bed?

____

How would you consider your present level of activity? ▢ Poor ▢ Fair ▢ Good

Please list your present hobbies:

____

____

_

Work/Occupation:

Please state what you do for a living:

____

Please indicate the hours you spend at work per week:

____

- OR -

If you are currently not working, how long have you not worked?

____

Are you not working for reasons other than your pain/problem? ▢ Yes ▢ No

If so, what reason?

____

Are you a full-time homemaker? ▢ Yes ▢ No

	Before pain/disability	**After pain/disability**
Hours per week spent working at a paying job:	___________	___________
Hours per week doing household chores:	___________	___________
Hours per week spent doing a volunteer job:	___________	___________

Are you presently receiving compensation (disability insurance)**?** ▢ Yes ▢ No

If not, are you considering or have you applied for compensation of any kind?

____

____

__

Patient Name: ______________________

If you anticipate returning to work, when do you hope to do so?

____

____

__

Please describe how your present living situation is different from the way it was before you experienced pain/disability problems:

____

____

__

____

__

Patient Name: ______________________

Current assistive devices:

Cane	▢ Yes	▢ No
Walker	▢ Yes	▢ No
Manual wheelchair	▢ Yes	▢ No
Motorized wheelchair	▢ Yes	▢ No
Corrective lenses/glasses	▢ Yes	▢ No
Hearing aids	▢ Yes	▢ No
Dentures	▢ Yes	▢ No
Prosthetics	▢ Yes	▢ No
Shunts	▢ Yes	▢ No
Pacemaker	▢ Yes	▢ No
Insulin pump	▢ Yes	▢ No
Baclofen pump	▢ Yes	▢ No

Other: ____

Present home environment:

Stairs, no railing	▢ Yes	▢ No
Stairs, railing	▢ Yes	▢ No
Ramps	▢ Yes	▢ No
Elevator	▢ Yes	▢ No
Uneven terrain	▢ Yes	▢ No
Bathroom modifications	▢ Yes	▢ No

Any other obstacles: ____

Current and past medical history:

▢ Alcoholism	▢ Allergies (please specify below)	▢ Alzheimer's Disease	▢ Arthritis
▢ Asthma	▢ Attention Deficit Disorder (ADD)	▢ Attention Deficit Hyperactivity Disorder (ADHD)	▢ Autoimmune Disease
▢ Back pain	▢ Bronchitis	▢ Cancer (please specify	▢ Carpal Tunnel

Patient Name: ______________________

		below)	Syndrome
▢ Cerebral Palsy	▢ Cholesterol, elevated	▢ Chronic Fatigue Syndrome	▢ Circulatory problems
▢ Colitis	▢ Dental problems	▢ Depression	▢ Diabetes
▢ Diverticular Disease	▢ Drug addiction	▢ Eating disorder	▢ Epilepsy
▢ Environmental sensitivities	▢ Eyes, ears, nose, throat problems	▢ Facial Palsy	▢ Fibromyalgia
▢ Food intolerance	▢ Gastrointestinal	▢ Genetic disorder	▢ Glaucoma
▢ Gout	▢ Headaches (please specify below)	▢ Heart Disease	▢ High Blood Pressure
▢ Infection, chronic (please specify below)	▢ Inflammatory Bowel Disease	▢ Irritable Bowel Syndrome	▢ Kidney or Bladder Disease
▢ Learning disabilities	▢ Liver or Gallbladder Disease (stones)	▢ Lymphedema	▢ Lymphatic problems
▢ Mental illness	▢ Mental retardation	▢ Migraines (please specify below)	▢ Mononucleosis
▢ Multiple Sclerosis	▢ Musculoskeletal problems	▢ Obesity	▢ Osteoporosis
▢ Paraplegia	▢ Parkinson's	▢ Phobias	▢ Pneumonia
▢ Quadriplegia	▢ Respiratory problems	▢ Rheumatoid Arthritis	▢ Seasonal Affective Disorder
▢ Sexually Transmitted Disease	▢ Sinus problems	▢ Skin problems	▢ Spina Bifida
▢ Stroke	▢ Thyroid trouble	▢ Traumatic Brain Injury (TBI)	▢ Tuberculosis
▢ Ulcer	▢ Urinary Tract Infection	▢ Varicose Veins	

▢ Other (please specify below)

Allergies (type): ____

Cancer (type): ____

Headaches: Frequency ____________________ Duration: ________________ Intensity (range 0-10): ____

Infection, chronic (type): ____

Migraines: Frequency _____________________ Duration: ________________ Intensity (range 0-10): ____

Other: ____

____

____

Medical (men):

▢ Benign Prostatic Hypertrophy ▢ Decreased sex drive ▢ Infertility

▢ Prostate Cancer ▢ Sexually Transmitted Disease ▢ Other (please specify below)

Other: ____

____

____

Medical (women):

▢ Breast Cancer ▢ Breast surgery/reduction/implants ▢ Decreased sex drive

▢ Endometriosis ▢ Fibrocystic breasts ▢ Fibroids/ovarian cysts

▢ Infertility ▢ Menstrual irregularities ▢ Pelvic Inflammatory Disease

Patient Name: ______________________

- ▢ PMS
- ▢ Sexually Transmitted Disease
- ▢ Vaginal Infections
- ▢ Other (please specify below)

What was the date of onset of last menses? ____

Other:
____

____

____

List all trauma and when it occurred (all trauma, accidents and injuries are important, not just recent ones):

____

____

____

List any operations you have undergone and dates (approximately):
____

____

____

____

List any hospitalizations and dates (approximately):
____

____

____

____

Patient Name: ______________________

What was your last vaccination/inoculation?

____

Did you become ill? ▢ Yes ▢ No

When have you traveled out of the country?

____

Did this require inoculation? ▢ Yes ▢ No

Did you become ill? ▢ Yes ▢ No

Are you losing weight without trying? ▢ Yes ▢ No

Are you coughing up blood or noticing it in your stool or urine? ▢ Yes ▢ No

Have you lost consciousness or had double vision recently? ▢ Yes ▢ No

<u>Family health history:</u>

▢ Alcoholism	▢ Alzheimer’s Disease	▢ Arthritis	▢ Asthma
▢ Cancer	▢ Depression	▢ Diabetes	▢ Drug addiction
▢ Eating disorder	▢ Genetic disorder	▢ Glaucoma	▢ Heart Disease
▢ High blood pressure	▢ Infertility	▢ Learning disabilities	▢ Mental illness
▢ Mental retardation	▢ Migraine headaches	▢ Neurological disorders (Parkinson’s, paralysis)	▢ Obesity
▢ Osteoporosis	▢ Rheumatoid Arthritis	▢ Stroke	▢ Other (please specify below)

Other:

____

____

____

Patient Name: ______________________

Health habits:

▢ Tobacco: # cigarettes/day _____ # cigars/day _____ pipe _____ chewing _____

▢ Alcohol: # glasses of wine or beer/day or week _____ # ounces liquor/day or week _____

▢ Caffeine: # 6 oz. cups of coffee/day _____ # 6 oz. cups of tea/day _____

cans of soda w. caffeine/day _____ # cans of diet soda/day _____

▢ Other:

____

____

____

Exercise: (Check all that apply)

Frequency: ▢ 5-7 days/week ▢ 3-4 days/week ▢ 1-2 days/week ▢ Infrequent ▢ Never

Duration: ▢ 45 min or more/workout ▢ 30-45 min/workout ▢ Less than 30 min/workout

Type: ▢ Walk ▢ Swim ▢ Run, jog, jump rope ▢ Box ▢ Yoga

▢ Other:

____

____

____

Nutrition and diet:

▢ Vegetarian ▢ Vegan ▢ High protein

▢ Salt restriction ▢ Low fat diet ▢ Starch/carbohydrate restriction

▢ The Zone Diet ▢ Atkins Diet ▢ Other (please specify below)

Other:

____

____

____

Patient Name: ______________________

__

Specific food restrictions:

▢ Dairy ▢ Eggs ▢ Soy ▢ Corn ▢ Gluten ▢ Wheat ▢ Sugar

▢ Other: ____

Circle the level of stress you are experiencing on a scale of 1-10 (1 being the lowest):

1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (i.e. changes in job, work, residence or finances, legal problems):

____

__

____

__

____

__

List any prescribed, over the counter medications and/or supplements you are taking.

Current medications/supplements	Dosage	How long have you been taking them?	Any other medications/supplements you have taken during the past 5 years

(Attach a piece of paper if needed).

Patient Centered Goals

A goal list will help us recognize what you would like to accomplish.

Patient Name: ______________________

The following examples are provided to assist you to answer:

“I know I will be better when I can…”

Example 1) Walk independently for 15 minutes with no pain.

Example 2) Work using just a splint for a half day with occasional pain.

Example 3) Sit with the help of only one person for 30 seconds.

Example 4) Play 18 holes of golf without pain in my back.

Please fill in the chart below, answering “I know I will be better when I can…”

1) ____

2) ____

3) ____

4) ____

5) ____