# SRT® Client History

Aruna Ramamurthy

## GENERAL INFORMATION

Please circle and fill in all applicable items

Name: Last__________________ First_____________ Age___ Date of Birth___/___/___ M F

Address______________________________ City_____________ State____ Zip________

Home phone _____/______/________ Work or cell phone _____/______/________

Found out about us: phone book, sign, web, referred by:______________________________

Occupation__________________________ Employer______________________________

Emergency contact______________________________ Phone______________________

For office only

Client # ________

Date___/___/___

DOE___/___/___

DOI ___/___/___

Referral Y N

Prior Client Y N

## PAYMENT INFORMATION

Payment will be by: Cash Check Credit Card ~~Auto Ins.~~ ~~Other Ins.~~

*(Please fill in if you are paying for care by insurance or personal check)

*Gov ID#___________________________ or *Drivers Lic.# or Student ID #____________________

~~Insurance Company~~____________________ ~~Policy #~~______________ ~~Group #~~__________

~~Member #~~__________________ ~~Benefits Phone #~~____________________ ext.__________

## CURRENT COMPLAINTS

1.________________________ How long _________ Getting: Worse Better Prior History Y N

2.________________________ How long _________ Getting: Worse Better Prior History Y N

3.________________________ How long _________ Getting: Worse Better Prior History Y N

4.________________________ How long _________ Getting: Worse Better Prior History Y N

Are your current complaints due to an injury Y N Auto Work Sports Other______________

Has an accident been reported Y N Have you retained an attorney Y N Name______________

## PRIOR TREATMENT

Have you been treated for the above complaints by a: Chiropractor Physical Therapist Naturopath Osteopath MD Acupuncturist? Name of treating provider ______________________________

When?__________________ Results of treatment______________________________

Have you ever received Massage Therapy? Y N Name______________________ When ________

## SUBJECTIVE STATUS

**Primary (#1) complaint severity scale**

less 0 1 2 3 4 5 6 7 8 9 10 more

**P** = Pain

**A** = Ache

**S** = Stiff

**B** = Burn

**Sh**=Shooting

**Sp**=Spasm

**N** = Numb

**T** = Tingling

**Front** — **Right** **Left**

**Back** — **Left** **Right**

Staff or Therapist's Notes Only

Staff

Therapist's Notes Only

Ther.

# SRT® Client History

Aruna Ramamurthy

**Please complete the following before care is considered**
Circle all current conditions –**AND**– all recurrent conditions –**AND**– all previously diagnosed conditions rendered from a health care provider

| Client only | Notes ONLY | Client only | Notes ONLY | Client only | Notes ONLY | Client Only | Notes ONLY |
|---|---|---|---|---|---|---|---|
| Allergies | ____ | Shoulder pain | ____ | Asthma | ____ | Spitting blood | ____ |
| Chills | ____ | Elbow / Wrist pain | ____ | Emphysema | ____ | Blood in urine | ____ |
| Convulsions | ____ | Knee / foot pain | ____ | Deafness | ____ | Blood in stool | ____ |
| Dizziness | ____ | Swollen joints | ____ | Ear noises | ____ | Freq. urination | ____ |
| Fainting | ____ | Belching or gas | ____ | Thyroid disease | ____ | Diff. holding urine | ____ |
| Fatigue | ____ | Indigestion | ____ | Hoarseness | ____ | Painful urination | ____ |
| Headache | ____ | Acid reflux | ____ | Bleeding | ____ | Prostate disease | ____ |
| Loss of sleep | ____ | Irritable bowel | ____ | Easy bruising | ____ | Painful periods | ____ |
| Weight gain | ____ | Diarrhea | ____ | Ear pain | ____ | Breast implants | ____ |
| Nervousness | ____ | Excess hunger | ____ | Chest pain | ____ | Pregnancy | ____ |
| Nerve pain | ____ | Jaundice | ____ | High blood pressure | ____ | Seizures | ____ |
| Night sweats | ____ | Hepatitis | ____ | Low blood pressure | ____ | Depression | ____ |
| Numbness | ____ | Liver disease | ____ | Heart pain | ____ | Anxiety | ____ |
| Recur. twitches | ____ | Gall Blad. Disease | ____ | Heart disease | ____ | Cancer | ____ |
| Tremors | ____ | Aids | ____ | Strokes | ____ | Diabetes | ____ |
| Difficult breathing | ____ | Pancreatic disease | ____ | Ankle swelling | ____ | Contagious dis. | ____ |
| Neck pain | ____ | Kidney disease | ____ | Feet swelling | ____ | Lupus | ____ |
| Thoracic pain | ____ | Nausea | ____ | Varicose veins | ____ | Multiple Sclerosis | ____ |
| Low back pain | ____ | Abdominal pain | ____ | Skin disease | ____ | Head injury | ____ |

## OTHER HEALTH INFORMATION

**Surgeries:** **Initial here** ☐ **if you have Never had any surgeries.**

| List all surgeries | Dates | List all surgeries | Dates |
|---|---|---|---|
| ____ | ____ | ____ | ____ |
| ____ | ____ | ____ | ____ |
| ____ | ____ | ____ | ____ |

**Injuries:** **Initial here** ☐ **if you have NEVER had any injuries.**

List all accidents resulting in treatable injuries. Include auto and spinal injuries — List all dates

______________________________ ____
______________________________ ____

**Spinal History:** **Initial here** ☐ **if you have NEVER had any non-surgical spinal procedures.**

List all non-surgical procedures including spinal taps, injections, braces, etc. — List all dates

______________________________ ____
______________________________ ____
______________________________ ____

**List all Medications and Nutritionals:** **Initial here** ☐ **if you DO NOT take medications, nutritional supplements, or herbs**

______________________________
______________________________

**Please list all disease (diabetes, lupus, liver, kidney, cancer, etc. ) for:**

Your self ______________________________

Your immediate family ______________________________

Do you: Smoke Y N ________ per day Drink alcohol Y N ________ per day Exercise ________ x / week.

**Do you have any history of cancer Y N If yes, what type and when** ______________________________

**Statement of Accuracy and Consent to Treat:**
By signing below, I agree that I have completed the above form and I have not omitted, nor misrepresented any requested health information and that as with all health care protocols, there is an inherent risk of post treatment soreness and/or aggravation of known and unknown pre-existing conditions. I further understand that the inherent risks noted above are substantially less than the adverse effects of NSAIDS and various other medications for the control of muscular skeletal dysfunction. I fully understanding the above and give my full consent for assessment and treatment according to the standards and practices of soft tissue therapy.

Signature of client or guardian ______________________________ Date ____/______/______



®Registered Copyright SRI, Intl. and LFI, LLC 2011