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
FAX: 785-271-9257
WEBSITE: www.ctrmm.com

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Name:_____ DOB: _____ Today's Date:_____

What is your main complaint today?_____

_____

Primary Care Physician:_____

Date current problem started: _____

If you would like access to our patient portal please provide your email:

_____

Are you experiencing any other joint pain today?

Yes No

Occupation: _____

Explain:_____

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

Medications or treatment for this condition:

Explain: _____

_____

Do you have a durable power of attorney?

Yes No

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	_____	_____

Do YOU PERSONALLY have any of the following conditions?

Please Circle YES or NO

Yes No History of Cancer?

Type: _____

Yes No Have Diabetes? Last A1C: _____

Yes No Past/Current use of cortisone or prednisone?

Yes No Osteoporosis?

Yes No Bowel or Bladder Issues?

Yes No Recent Fever?

Yes No Gastro-Intestinal Issues?

Yes No Unexplainable Weight Loss/Gain?

Yes No Heart Condition?

Yes No High Blood Pressure?

Yes No Epilepsy?

Yes No History of stroke?

Date (s):_____

Yes No Do you use tobacco products (Circle all that apply)

Vape Cigarettes Smokeless (Chew)

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?

Yes No Depression/Anxiety/Psychiatric History?

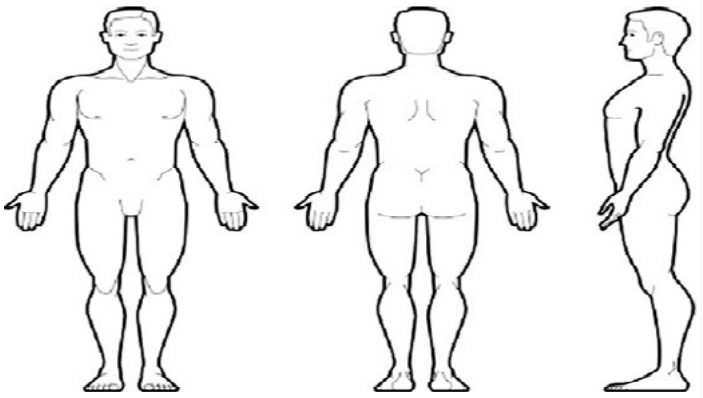
Elaborate: _____ _____

Yes No Have you fallen in the last 3 months?

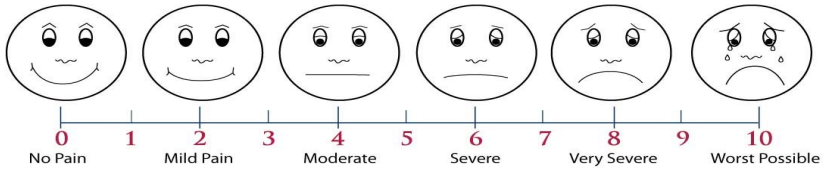
Yes No Were you injured?

Elaborate: _____

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.



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? _____

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

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: _____