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:____

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

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: ____________________________________

DOB: ______________________ Today's Date:_________________

Primary Care Physician:_____________________________________

Occupation: ____

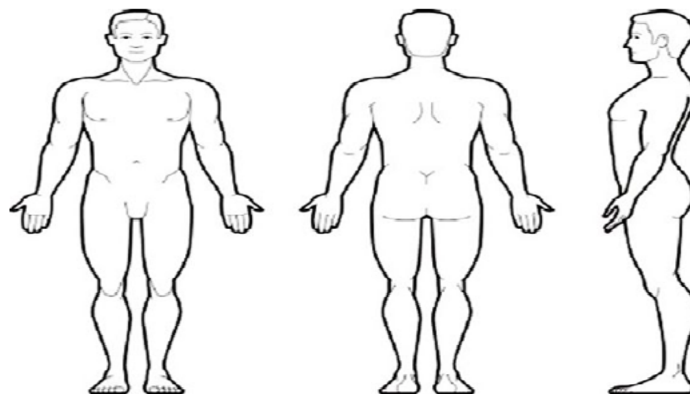
Is today's visit due to work or motor vehicle accident? Yes No

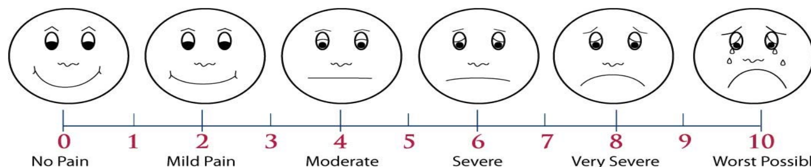
Explain: ____

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.

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:____________________

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: _______________________________