PT Short Form

Thank you for your support.
Please complete this form on all consecutive patients throughout your participation, no exceptions (even if the patient decides not to complete their form or is non-English speaking).

Patient Data

1) Age _____ months / years *(circle one)* **2)** Gender ☐ Male ☐ Female
3) Presenting Condition(s): ☐ Preventative/Wellness/No Symptoms ☐ Headache ☐ Neck Pain
☐ Thoracic Back Pain ☐ Low Back Pain ☐ Extremity pain ☐ Other, specify _____
4) Radicular Pain? ☐ Yes ☐ No **5)** Please indicate if the primary condition is: ☐ Chronic ☐ Acute
6) Any manual therapy within the last week? ☐ Yes ☐ No
7) How long has this patient been receiving manual therapy? _____ months / years *(circle one)*

Treatment *(as comprehensive as possible, please describe the therapy that you provided for this patient today)*

	Specific Area / Spinal Level	Grade	Direction	More information:
Manual Therapy #1	☐C ☐T ☐L ☐P ☐U/E ☐L/E	☐1 ☐2 ☐3 ☐4 ☐5	☐Flex ☐Ext ☐Rot ☐Side	
Manual Therapy #2	☐C ☐T ☐L ☐P ☐U/E ☐L/E	☐1 ☐2 ☐3 ☐4 ☐5	☐Flex ☐Ext ☐Rot ☐Side	
Manual Therapy #3	☐C ☐T ☐L ☐P ☐U/E ☐L/E	☐1 ☐2 ☐3 ☐4 ☐5	☐Flex ☐Ext ☐Rot ☐Side	
Non-manipulation therapies:	☐ Exercise(s) ☐ Stretch(es) ☐ Acupuncture / Acupressure ☐ Other, please descrive:			

Adverse Event

Was there any adverse event after the manual therapy treatment? ☐ No ☐ Yes *(complete table below)*

Adverse Event *(check all that apply)*	Location *(if applicable)*	Anticipated	Overall Severity Rating
☐ Discomfort/Pain		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Stiffness		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Weakness		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Fatigue/Tiredness		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Headache		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Dizziness		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Difficulty with vision		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Sleeping Disturbances		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Irritability / Crying		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Dysarthria		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Nausea/Vomiting		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Numbness/Tingling		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Strains/Sprains		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Gait Disturbances		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious
☐ Other: _____		☐ Yes ☐ No	☐ Mild ☐ Moderate ☐ Severe ☐ Serious