

Bobby Bruce LMT/MMP	CLINIC:	Bobby Bruce LMT/MMP	PHONE:	2566134159
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PATIENT INFORMATION		
FIRST NAME	LAST NAME	EMAIL

ADDITIONAL INFORMATION		
DATE OF BIRTH	GENDER	

CONTACT INFORMATION		
HOME PHONE	WORK PHONE	CELL PHONE
ADDRESS		CITY
PROVINCE / STATE	COUNTRY	POSTAL / ZIP CODE

EMERGENCY CONTACT		
NAME	PHONE	RELATIONSHIP TO PATIENT

PATIENT HISTORY		
OCCUPATION	SOURCE OF REFERRAL	CURRENT TREATMENT WITH OTHER PRACTITIONERS
PRIMARY COMPLAINT		
PAST TREATMENT WITH OTHER PRACTITIONERS	GENERAL HEALTH	

DOCTOR INFORMATION		
PHYSICIAN'S NAME	PHYSICIAN ADDRESS	PHYSICIAN PHONE

PATIENT CONDITIONS

Area of Complaint

- | | | | |
|-------------------------------------------------|--------------------------------------------------|-----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Ankles (Left) | <input type="checkbox"/> Ankles (Right) | <input type="checkbox"/> Arms (Left) | <input type="checkbox"/> Arms (Right) |
| <input type="checkbox"/> Elbow (Left) | <input type="checkbox"/> Elbow (Right) | <input type="checkbox"/> Feet (Left) | <input type="checkbox"/> Feet (Right) |
| <input type="checkbox"/> Hands (Left) | <input type="checkbox"/> Hands (Right) | <input type="checkbox"/> Hips (Left) | <input type="checkbox"/> Hips (Right) |
| <input type="checkbox"/> Knees (Left) | <input type="checkbox"/> Knees (Right) | <input type="checkbox"/> Legs (Left) | <input type="checkbox"/> Legs (Right) |
| <input type="checkbox"/> Low Back (Left Side) | <input type="checkbox"/> Low Back (Right Side) | <input type="checkbox"/> Mid Back (Left Side) | <input type="checkbox"/> Mid Back (Right Side) |
| <input type="checkbox"/> Neck (Left Side) | <input type="checkbox"/> Neck (Right Side) | <input type="checkbox"/> Shoulders (Left) | <input type="checkbox"/> Shoulders (Right) |
| <input type="checkbox"/> Upper Back (Left Side) | <input type="checkbox"/> Upper Back (Right Side) | <input type="checkbox"/> Wrist (Left) | <input type="checkbox"/> Wrist (Right) |

Headaches

- | | | | |
|-------------------------------------------------|----------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Chronic Daily Headache | <input type="checkbox"/> Cluster | <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Rebound | <input type="checkbox"/> Sinus | <input type="checkbox"/> Tension | |

Blood

- | | | | |
|----------------------------------------------|--------------------------------------------|---------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Haemophilia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> HIV | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Hypercoagulability | <input type="checkbox"/> Polycythemia |
| <input type="checkbox"/> Thrombosis/Embolism | | | |

Cardiovascular

- | | | | |
|---------------------------------------------------------|-------------------------------------------------------|--------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Acute Coronary Syndrome | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Angina | <input type="checkbox"/> Atherosclerosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Cardiac Arrhythmia | <input type="checkbox"/> Cardiovascular Accident | <input type="checkbox"/> Cardiovascular Conditions |
| <input type="checkbox"/> Chronic Ischemic Heart Disease | <input type="checkbox"/> Chronic Venous Insufficiency | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Cold Hands |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pericarditis |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Raynaud Disease | <input type="checkbox"/> Rheumatic Heart Disease | <input type="checkbox"/> Valve Disorders |
| <input type="checkbox"/> Varicose Veins | | | |

Emotion & Memory

- | | | | |
|--------------------------------------------|-------------------------------------------------|----------------------------------------|----------------------------------------|
| <input type="checkbox"/> Alzheimer Disease | <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Mood Disorder | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Stress | <input type="checkbox"/> Substance Use Disorder | | |

Endocrine

- | | | | |
|--------------------------------------------------------|-----------------------------------|------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Acute Pancreatitis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Pituitary and Growth Disorder | | | |

Gastrointestinal

- | | | | |
|-----------------------------------------------|---------------------------------------------|---------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Constipation | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Digestive Conditions | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Esophageal Disorder |
| <input type="checkbox"/> Fecal Impaction | <input type="checkbox"/> Intestinal Polyps | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Poor Appetite |
| <input type="checkbox"/> Stomach Disorder | <input type="checkbox"/> Ulcerative Colitis | | |

Hearing

- | | | | |
|--------------------------------------------------|---------------------------------------|---------------------------------------|------------------------------------------|
| <input type="checkbox"/> Conductive Hearing Loss | <input type="checkbox"/> Ear Problems | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Meniere Disease |
| <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Tinnitus | <input type="checkbox"/> Vertigo | |

Immune

- | | | | |
|---------------------------------------------------|--------------------------------------|---------------------------------|-----------------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hodgkin Lymphoma |
| <input type="checkbox"/> Infectious Mononucleosis | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Lupus | <input type="checkbox"/> Non-Hodgkin Lymphoma |
| <input type="checkbox"/> Rheumatoid Arthritis | | | |

Kidney

- | | | | |
|-------------------------------------------|-------------------------------------------------|----------------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Bladder Disorder | <input type="checkbox"/> Chronic Kidney Disease | <input type="checkbox"/> Congenital Kidney Disease | <input type="checkbox"/> Electrolyte Imbalance |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Renal Cysts | <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Urinary Tract Infection |

Musculoskeletal

- | | | | |
|--------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS) | <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints / Special Equipment |
| <input type="checkbox"/> Bone Disease | <input type="checkbox"/> Compartment Syndrome | <input type="checkbox"/> Dislocation | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Gout | <input type="checkbox"/> Hereditary/Congenital Deformity | <input type="checkbox"/> Jaw Pain (TMJD) |
| <input type="checkbox"/> Joint Injury | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Myasthenia Gravis | <input type="checkbox"/> Osgood-Schlatter Disease |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Osteomalacia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Paget Disease |

<input type="checkbox"/> Psoriatic Arthritis	<input type="checkbox"/> Scleroderma	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Strain/Sprain			
Neurological			
<input type="checkbox"/> Brain Disorder	<input type="checkbox"/> Brain Injury	<input type="checkbox"/> Burning	<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Cerebral Vascular Accident (Stroke)	<input type="checkbox"/> Cerebral-vascular Accident	<input type="checkbox"/> Chronic Pain Disorder	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Herniated Disc	<input type="checkbox"/> Huntington Disease	<input type="checkbox"/> Loss of Sensation
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Numbness	<input type="checkbox"/> Parkinsons	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Shingles	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Stroke	<input type="checkbox"/> Tingling
<input type="checkbox"/> Transient Ischemic Attacks (TIA)	<input type="checkbox"/> Vertebral and Spinal Cord Injury		
Reproductive			
<input type="checkbox"/> Breast Disorder	<input type="checkbox"/> Ectopic Pregnancy	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Gynaecological Conditions
<input type="checkbox"/> Menopause	<input type="checkbox"/> Menstrual Cycle Disorder	<input type="checkbox"/> Ovarian Cysts/Tumors	<input type="checkbox"/> Pelvic Inflammatory Disease
<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Premenstrual Syndrome	<input type="checkbox"/> Uterine Disorder	
Respiratory			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> COPD
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Infectious Respiratory Conditions	<input type="checkbox"/> Respiratory Conditions
<input type="checkbox"/> Respiratory Tract Infection	<input type="checkbox"/> Shortness of Breath		
Skin			
<input type="checkbox"/> Acne	<input type="checkbox"/> Allergic Dermatitis	<input type="checkbox"/> Athlete's Foot	<input type="checkbox"/> Athletes Foot
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Chemical Burn	<input type="checkbox"/> Herpes	<input type="checkbox"/> Hypersensitive Reaction
<input type="checkbox"/> Hypersensitive Reactions	<input type="checkbox"/> Infectious Skin Conditions	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Melanoma/Carcinoma
<input type="checkbox"/> Pigmentary Disorder	<input type="checkbox"/> Plantar's Wart	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Rash
<input type="checkbox"/> Rosacea	<input type="checkbox"/> Skin Conditions	<input type="checkbox"/> Skin Irritations	<input type="checkbox"/> UV Burn
Miscellaneous			
<input type="checkbox"/> Insomnia	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Other Diagnosed Diseases	<input type="checkbox"/> Other Medical Conditions
<input type="checkbox"/> Surgical Pins or Wire	<input type="checkbox"/> Vision Loss	<input type="checkbox"/> Vision Problems	

ADDITIONAL INFORMATION		
MEDICATIONS	INJURIES	SURGERIES
SUBJECTIVE		