Chart Number: ___________________________

Date___________________________ Age______________

Name____

ATTENTION, PATIENTS: Please complete this form in its entirety front and back, sign, date, and please provide the date of your next visit with the physician who referred you for this visit. Thank you!

GENERAL MEDICAL HISTORY

1. Please check the appropriate box if you have any of the following:

- □ **N/A**
- □ Cancer
- □ Unexplained weight loss
- □ Current infection/infectious disease
- □ Incontinence (Bladder/bowel)
- □ Fractures/suspected fractures
- □ Cauda equine/progressive neurological deficit/numbness and tingling in saddle region

HISTORY OF CURRENT CONDITION

2. Which of the following *best describes* how your injury occurred? (If your injury is post-surgical please indicate as per the original injury).

- □ Lifting
- □ A fall
- □ Overuse (cumulative trauma)
- □ During recreation/sports
- □ MVA (car accident) in state: ____
- □ Degenerative Process
- □ An incident at work
- □ Unknown
- □ Other: ________________

Date of injury:_________________________________

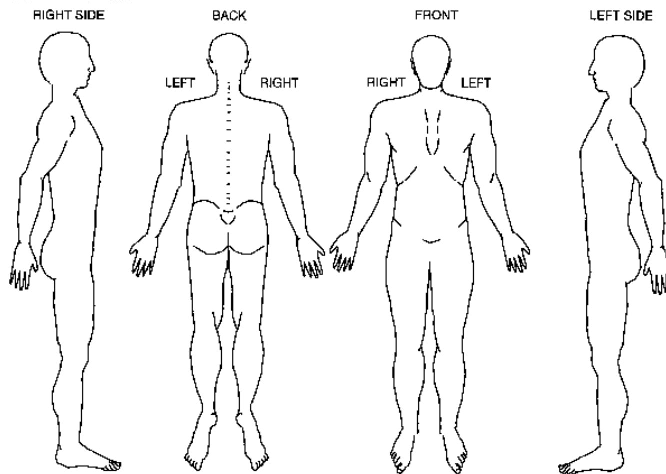
Surgery for this injury? □ Yes □ No

If yes, list surgery date:___________________________

3. Nature of primary complaint (check all that apply):

□ Pain	□ Numbness/Tingling	□ Sharp
□ Aching	□ Constant	□ Dull
□ Burning	□ Weakness	□ Intermittent
□ Throbbing	□ Other _____________	

Using the key below, indicate on the body diagrams where your symptoms are located X = PAIN O = TINGLING // = NUMBNESS



Place an "X" on the line below indicating your pain at its lowest and highest levels.

☺ 0___ 1____2____3____4____5____6____7____8____9____10 ☹

4. What relieves (R) or aggravates (A) your symptoms: (please circle (R) or (A) next to each activity).

1. Sitting: (R) (A)	8. Coughing/sneezing: (R) (A)
2. Rest: (R) (A)	9. Walking: (R) (A)
3. Exercise: (R) (A)	10. Medication: (R) (A)
4. Heat: (R) (A)	11. Stretching: (R) (A)
5. Standing: (R) (A)	12. Lying down: (R) (A)
6. Massage: (R) (A)	13. Wearing a splint/brace: (R) (A)
7. Cold : (R) (A)	14. N/A

5. Does pain related to this injury wake you up at night?

□ Yes □ No

If yes, is it present:

□ While lying still □ When changing positions □ Both

6. Do you have pain / stiffness getting out of bed in the morning that is related to this injury? □ Yes □ No

7. Since your symptoms began have you had: □ None of these

- □ Fever/chills/nausea/vomiting
- □ Any numbness in genital/anal area
- □ Numbness/tingling/burning
- □ Problems with hearing/vision/speech
- □ Other: ____
- □ Night sweats/pain
- □ Headaches
- □ Weakness

8. Treatment previously received for this condition? □ None

- □ Medication
- □ Chiropractic treatment
- □ Physical therapy
- □ Casting/immobilization
- □ Injections/acupuncture
- □ Speech/occupational therapy (list dates) ____________________________
- □ Bracing/taping
- □ TENS unit
- □ Massage
- □ Hospitalization
- □ Other_____________
- □ Home health (dates) _________________

9. Please check any other health care providers you are currently seeing for this condition: □ None

□ Primary MD (Name) ___________________________ □ Dentist

□ Podiatrist □ Chiropractor □ Physical Therapist

10. Please check if you have had any of the following?

□ None □ EMG □ X-Rays □ MRI □ CT Scan

□ Myelogram □ Nerve Conduction Study

PLEASE COMPLETE INFORMATION ON THE NEXT PAGE!

Chart Number: ___________________________

____

GENERAL HEALTH

-How would you rate your overall health?

□ Excellent □ Good □ Average □ Fair □ Poor

-Are you pregnant? □ No □ Yes, and the due date is____________

-Do you smoke? □ No □ Yes

-Apart from your daily activities do you exercise?

□ 5+ days per week □ 3-4 days/wk □ 1-2 days/wk

□ Occasionally □ Rarely □ Never

MEDICATIONS

Please list all prescriptions and/or over-the-counter medications you are currently taking:

□ See attached list □ N/A

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PAST/CURRENT MEDICAL HISTORY

Have you ever been diagnosed with any of the following conditions?

□ None
□ High blood pressure
□ Heart Problems
□ Pacemaker
□ Heart defibrillator
□ Stroke
□ HIV
□ Kidney problems
□ Thyroid problems
□ Epilepsy/seizure/dizziness
□ Circular/vascular problems
□ Depression
□ Chemical dependency
□ Spine surgery
□ Lung problems/asthma
□ Multiple sclerosis
□ Allergies
□ Stomach problems
□ Parkinson's
□ Head injury
□ Arthritis
□ Spine problems
□ Diabetes
□ **List all other surgeries**____________________________

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PREVIOUS FUNCTIONAL LEVEL

□ Independent in all activities (work, home, recreation)
□ Self Care
□ Independent (bathing, toileting, dressing, etc.)
□ Difficulty in performing self care activities
□ Need assistance with self-care activities
□ Difficulty in performing household chores

Social/ Recreation/ Leisure
□ Limited in ________________________________

GENERAL MEDICAL HISTORY

Physical activities at work: (if out of work, answer according to most recent work history).

□ Sitting □ Standing □ Computer Use
□ Phone use □ Driving □ Repetitive lifting
□ Heavy lifting □ Walking □ Bending
□ Crawling □ Heavy equipment operation
□ N/A

Current working status

□ Full duty □ Restricted duty □ Out on leave
□ Retired □ Disabled □ Part-time

If not performing your normal activities at work, do you plan to return to your previous activity level? □Yes □ No

If you were injured on the job, please describe briefly how the incident occurred.

____

____

____

____.

My follow-up appointment with the referring doctor is:

____

X____

Patient/Guardian Signature

____

Therapist Signature