

PATIENT INFORMATION/ MEDICAL HISTORY

PATIENT NAME _____ DATE _____ AGE _____
DATE OF BIRTH _____ SOCIAL SECURITY # _____
ADDRESS _____
HOME PHONE _____ ALT PHONE _____
EMAIL ADDRESS _____
PHYSICIAN(S) _____
DATE OF NEXT VISIT TO PHYSICIAN _____
ARE YOU PRESENTLY WORKING (Y/N) OCCUPATION _____
HAND DOMINANCE (LEFT/RIGHT) LEG DOMINANCE (LEFT/RIGHT)
DESCRIBE YOUR CHIEF COMPLAINT _____

WHAT IS YOUR FUNCTIONAL GOAL _____
DATE OF INJURY _____
DESCRIBE THE CAUSE AND HISTORY OF YOUR SYMPTOMS _____

IF YOU HAD THESE SYMPTOMS BEFORE, WHAT TREATMENT IF ANY ALLEVIATED THEM _____

ARE YOUR SYMPTOMS (IMPROVING/UNCHANGED/WORSENING)
RATE THE INTENSITY OF YOUR RESTING PAIN, ON A SCALE OF 0 TO 10, WITH 0 BEING NO PAIN AND 10 BEING THE WORST PAIN POSSIBLE _____
IS YOUR PAIN (CONSTANT/ INTERMITTENT)

WHAT ACTIVITIES MAKE YOUR SYMPTOMS WORSE? (Please Circle)
Bending Sitting/Rising Standing Walking Lying Stationary
(a.m./ as the day progresses/ p.m.) cough/sneeze/strain

WHAT ACTIVITIES MAKE YOUR SYMPTOMS BETTER? (Please Circle)
Bending Sitting/Rising Standing Walking Lying Stationary
(a.m./ as the day progresses/ p.m.) cough/sneeze/strain

HAVE YOU HAD A RELATED SURGERY (Y/N) IF YES, DATE OF SURGERY _____

WHAT DIAGNOSTIC TESTES HAVE YOU HAD (X-RAY/MRI/CT SCAN)
RESULTS _____

LIST PRESENT MEDICATION AND CONDITION FOR TAKING MEDICATION _____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING (PLEASE CIRCLE)

Diabetes	Chest Pain/Angina	Heart Disease/High B.P.
Heart Attack	Heart Palpitations	Pacemaker
Headaches	Kidney Problems	Are you Pregnant
Cancer	Nausea/Vomiting	Asthma/Breathing Problems
Rheumatoid Arthritis	Scoliosis	Liver/Gall Bladder Problems
Allergies to Aspirin	Smoking	Poor Tolerance to Heat/Cold
Other Allergies	Hernia	Metal Implants
Dizziness/Fainting	Fractures	Surgeries
Seizures	Arthritis	Ringings in your ears

Special Diet Guidelines Leg Length Difference Bowel/Bladder Abnormalities

IF YOU ANSWERED YES ON ANY OF THE ABOVE, PLEASE BRIEFLY EXPLAIN AND GIVE APPROXIMATE DATE _____

IS THERE ANY OTHER INFORMATION REGARDING YOUR PAST MEDICAL HISTORY THAT WE SHOULD KNOW _____

DO YOU PARTICIPATE IN ANY SPORTS, EXERCISE PROGRAMS, OR ACTIVITIES ON A REGULAR BASIS _____

CONTACT PERSON _____ PHONE # _____

SIGNATURE _____ REL. TO PATIENT _____ DATE _____