Medical History Form

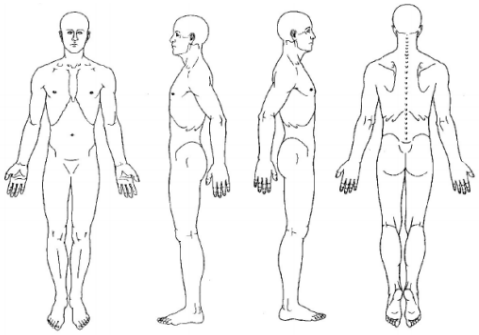
Date _____
Name_____
Occupation_____Currently Working? Yes/No
Rehabilitation goals _____
_____
Current Restrictions_____

History of Current Injury

Date of Injury or Estimated Onset___/___/_____ Date of Surgery___/___/_____

Cause of injury/symptoms _____
_____

Tell us about your pain



Please use the diagram to indicate the location of your symptoms and check the appropriate words below that best describe your pain/symptoms

__Dull Ache	__Sharp/Stabbing	__Stiffness
__Burning	__Numbness/Tingling	__Radiating
__Throbbing	__Constant	__Intermittent
__Weakness	__Swelling	

Other:_____

Rate the severity of your pain on a scale of 0 to 10
(0=no symptoms, 10= severe requiring visit to ER)
Current ___/10 Worst___/10 Best___/10

Are your symptoms getting ___Better ___Worse ___Same
Do your symptoms ease when you rest in a comfortable position? ___Yes___No
Do your symptoms disrupt your sleep?___Yes___No
Have you recently had a fever, infection, or other illness?___Yes___No
What makes you feel worse_____
What makes you feel better_____

Previous treatments for this condition

- Injections
- Medications
- Physical Therapy
- Surgery

Recent Diagnostic Studies

- X-Ray
- MRI
- Bone Scan
- CT Scan
- EMG

Medical History *Please mark below if you have been diagnosed with or received medical treatment for any of the following conditions*

- Diabetes
- High Blood Pressure
- Heart Condition
- Heart Attack
- Pacemaker
- Stroke or TIA
- Cancer _____
- Seizure or Epilepsy
- Rheumatoid Arthritis
- Other Arthritic Conditions_____
- Osteoporosis or Osteopenia
- Neurological Condition_____
- Severe Headache or Migraine
- Dizziness or Frequent Falls
- Thyroid Condition
- Kidney Disease
- Bowel or Bladder Disorder
- Circulatory Problems or DVT
- Peripheral Neuropathy
- Anemia
- Asthma
- Pulmonary Condition
- Smoking ___packs per day
- Alcohol or Chemical Dependency
- Depression
- Anxiety
- Fibromyalgia
- Prior Fractures_____
- Latex Sensitive
- Hearing Loss
- Vision Problems
- Sleep Disorder

Do you ever feel unsafe in your home or threatened by a family member? Yes___No___

Are you now or could you possible be pregnant? Yes___ No___

Any recent changes in sleep quality, energy level, or uninterested in things you enjoy? Yes___No___
Do you regularly exercise? Yes__No__
#of days/week_____-

Please mark any of the following that are **New or Unusual for you:**

- Unexplained weight loss/gain
- Night Sweats
- Difficulty breathing
- Regular cough
- Heartburn/indigestion
- Heart racing/palpitations
- Excessive bleeding or easy bruising
- Skin Rash
- Constipation/Diarrhea
- Blood in stools or urine
- Problems urinating or incontinence
- Arm or leg swelling

Are you currently taking any of the following **Over the Counter medications**?

- Aspirin
- Advil, Motrin, or Ibuprofen
- Aleve
- Decongestants or Antihistamines
- Tylenol
- Antacid
- Laxatives
- Supplements/Vitamins

Please list your current prescription medications_____
_____
_____

Prior surgeries with approximate dates_____

_____
Patient Signature