MEDICAL HISTORY

Name:_____ DOB:_____

Referring Physician:_____Primary Physician:_____

Occupation:_____Full-time Part-time Unemployed (circle one)

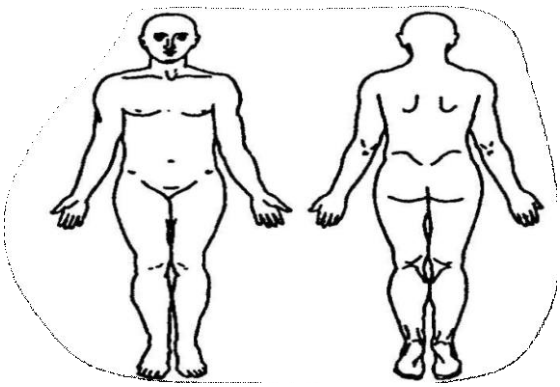
Date of Injury(If applicable):_____Last date worked due to injury:_____

INJURY DESCRIPTION

How did the injury occur? _____
Areas involved:_____
Was the injury work related? ___ Yes ___ No Auto accident related? ___ Yes ___ No
Have you ever been treated for this condition before? ____Yes ____ No
If yes, where did you receive treatment?_____
Please describe symptoms by checking all that apply: ____weakness ____stiffness
___shooting/sharp pain ____dull/aching pain ___numbness ___tingling ___burning
Other: _____
What increases your pain? _____
What decreases your pain?_____
Is your condition improving? ____Yes ___ No

FUNCTIONAL LIMITATIONS

How long can you sit?_____ How long can you stand?_____
How long can you walk? (min)_____Are stairs a challenge? __ Yes __ No
What is your biggest limitation at work?_____
What is your biggest limitation at home?_____
Average pain intensity last 24 hours:
no pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain
Average pain intensity past week:
no pain ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain
Please mark below with an **X** where you are currently experiencing your symptoms.



MEDICAL HISTORY (page 2)

Please list all medications with the doses you are taking, prescription or over-the-counter:

_____

_____

Are you allergic to any medications/latex? __ Yes __ No
If yes, please list:_____

Have you had surgery for this injury? __ Yes __ No
Type of surgery:_____Date:_____

What other tests (ie … x-ray, MRI) and/or treatments have you already received for this injury? Please list results:

_____

_____

_____

Do you now have or have you ever had **ANY** of the following?

	Yes	No		Yes	No
Asthma, bronchitis, or emphysema, shortness of breath/chest pain	___	___	Headaches	___	___
Coronary heart disease or angina	___	___	Vision or hearing difficulties	___	___
Do you have a pacemaker?	___	___	Numbness or tingling	___	___
High blood pressure	___	___	Dizziness of fainting	___	___
Heart attack or heart surgery	___	___	Bowel or bladder problems	___	___
Stroke/TIA	___	___	Weakness	___	___
Blood clot/Emboli	___	___	Weight loss/energy loss	___	___
Epilepsy/Seizures	___	___	Hernia	___	___
Thyroid disease or goiter	___	___	Varicose veins	___	___
Anemia	___	___	Any pins or metal implants	___	___
Infectious diseases	___	___	Joint replacement surgery	___	___
Diabetes	___	___	Neck injury/surgery	___	___
Cancer or chemotherapy/radiation	___	___	Shoulder injury/surgery	___	___
Arthritis	___	___	Elbow/hand injury/surgery	___	___
Osteoporosis	___	___	Back injury/surgery	___	___
Gout	___	___	Knee injury/surgery	___	___
Sleeping problems/difficulties	___	___	Leg/ankle/foot injury/surgery	___	___
Emotional/psychological problems	___	___	Are you pregnant?	___	___
			Do you use tobacco?	___	___

Patient/Guardian Signature:_____**Date**:_____