Medical History Form

What are you being seen for today?_____________________________________________________

What is your height _____ft _____in and weight ________ pounds

Date of injury or onset of symptoms: (best estimate) _____/_____/_____

What caused this injury/pain? __________________________________________________________

Is this a result of a workers compensation claim or motor vehicle accident? ☐ Yes ☐ No

Have you had surgery for your neck condition? ☐ Yes ☐ No
Have you had surgery for your back condition? ☐ Yes ☐ No

What type of surgery? __________________________ Date of surgery: ______________________

Surgeon: __________________________________________________________________________

Place check mark in front of all treatments received or medical professionals you have seen for your neck/back condition:

<table>
<thead>
<tr>
<th>Chiropractic</th>
<th>Medication</th>
<th>Traction</th>
<th>Pain Clinic</th>
<th>Rheumatologist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massage</td>
<td>Epidural</td>
<td>Ultrasound</td>
<td>Emergency</td>
<td>Occupational Medicine Doctor</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Trigger point injections</td>
<td>Bracing or Corset</td>
<td>Spine Surgeon Consult</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Electrical Stimulation</td>
<td>Work Hardening program</td>
<td>Urgent Care Clinic</td>
<td>Psychiatrist</td>
</tr>
<tr>
<td>Bed Rest</td>
<td>TENS</td>
<td>Home Exercise</td>
<td>Sports Medicine</td>
<td>Psychologist</td>
</tr>
</tbody>
</table>

Place check mark in front of any tests you have had for this condition:

<table>
<thead>
<tr>
<th>X-Ray</th>
<th>MRI</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT Scan (CAT scan)</td>
<td>Discogarme</td>
</tr>
<tr>
<td>EMG (needles in muscles to test nerves)</td>
<td>Bone Density Scan (for osteoporosis)</td>
</tr>
<tr>
<td>Myelogram</td>
<td>Bone Scan</td>
</tr>
<tr>
<td>None</td>
<td>Other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>History of cancer</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you recently had chest pain while exercising?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have a heart condition?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you experienced any changes with your bowel or bladder? (for example: sometimes you cannot start urination or sometimes you cannot stop your bowels from emptying)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you been diagnosed as having osteoporosis (thinning of the bones) or osteopenia (pre-osteoporosis)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are you currently working? __________________________________________________________

Are you under a medical doctor’s care for any other conditions? ☐ Yes ☐ No If yes, list reason(s): ______________________________________________________________
Mark the areas on the diagram below where you feel the described symptoms, using the appropriate symbol and include all affected areas.

Aching

Numbness

Pins and Needles

Sharp or Stabbing

Please circle the number that describes how bad your neck pain and/or arm pain/numbness/tingling has been over the last 48 hours:  No Symptoms 0 1 2 3 4 5 6 7 8 9 10 Worst possible symptoms

Please circle the number that describes how bad your back pain and/or arm pain/numbness/tingling has been over the last 48 hours:  No Symptoms 0 1 2 3 4 5 6 7 8 9 10 Worst possible symptoms

Check all that apply. My pain is worse:

<table>
<thead>
<tr>
<th>In the morning</th>
<th>Constant</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the day</td>
<td>With Activity</td>
</tr>
<tr>
<td>At night</td>
<td>During rest</td>
</tr>
</tbody>
</table>

What makes the pain better?

_____________________________________________________________________

What are your goals for physical therapy?

_____________________________________________________________________
# Medical History Form

## Review of Systems and Past Medical History

### Please check all that apply:

#### Constitutional
- [ ] fever
- [ ] chills
- [ ] weight change
- [ ] appetite change
- [ ] sweats
- [ ] sleep problems

#### Cardiovascular
- [ ] chest pain
- [ ] leg pain
- [ ] leg swelling
- [ ] varicose veins
- [ ] easy bruising
- [ ] palpitations
- [ ] high blood pressure

#### Respiratory
- [ ] tuberculosis
- [ ] cough
- [ ] asthma
- [ ] excess phlegm
- [ ] shortness of breath
- [ ] wheezing
- [ ] apnea

#### Musculoskeletal
- [ ] joint pain - list joint(s):
- [ ] joint swelling
- [ ] joint stiffness
- [ ] back pain
- [ ] neck pain

#### Neurological
- [ ] headache
- [ ] migraines
- [ ] fainting
- [ ] confusion
- [ ] seizures
- [ ] weakness
- [ ] difficulty speaking
- [ ] difficulty walking
- [ ] loss of balance/falls

#### Gastrointestinal
- [ ] difficulty swallowing
- [ ] heartburn
- [ ] abdominal pain
- [ ] nausea
- [ ] vomiting
- [ ] diarrhea
- [ ] constipation
- [ ] blood in stools

#### Urological
- [ ] difficulty urinating
- [ ] frequent urination
- [ ] night time urination
- [ ] pain with urination
- [ ] incontinence

#### Endocrine
- [ ] diabetes
- [ ] cold intolerance
- [ ] heat intolerance
- [ ] frequent thirst
- [ ] frequent urination
- [ ] loss of height

#### Integumentary
- [ ] rash
- [ ] changing mole(s)
- [ ] skin lesions
- [ ] jaundice

#### Mental Health
- [ ] sadness
- [ ] anxiety
- [ ] stress
- [ ] alcohol use
- [ ] caffeine use
- [ ] tobacco use
- [ ] other drug use

#### Other
- [ ] ________________________________
- [ ] history of cancer
- [ ] cancer treatment
- [ ] allergies _________________________
- [ ] glaucoma

#### Family History
- [ ] spine problems
- [ ] neurologic problems
- [ ] rheumatologic problems
- [ ] other