HealthPartners Physicians Neck & Back Center

Medical History Form

Patient information label

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:

	Chiropractic		Medication		Traction		Pain Clinic		Rheumatologist
	Massage		Epidural injections		Ultrasound		Emergency Room		Occupational Medicine Doctor
	Acupuncture		Trigger point injections		Bracing or Corset		Spine Surgeon Consult		General Practitioner
	Physical Therapy		Electrical Stimulation		Work Hardening program		Urgent Care Clinic		Physiatrist
	Bed Rest		TENS		Home Exercise		Sports Medicine		Psychologist

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

	X-Ray		MRI
	CT Scan (CAT scan)		Discogram
	EMG (needles in muscles to test nerves		Bone Density Scan (for osteoporosis)
	Myelogram		Bone Scan
	None		Other:

	Yes	No
History of cancer		
Have you recently had chest pain while exercising?		
Do you have a heart condition?		
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)		
Have you been diagnosed as having osteoporosis (thinning of the bones) or osteopenia (pre-osteoporosis)?		

Are you currently working? _____

Are you under a medical doctor's care for any other conditions? ☐Yes ☐No If yes, list reason(s):

_____

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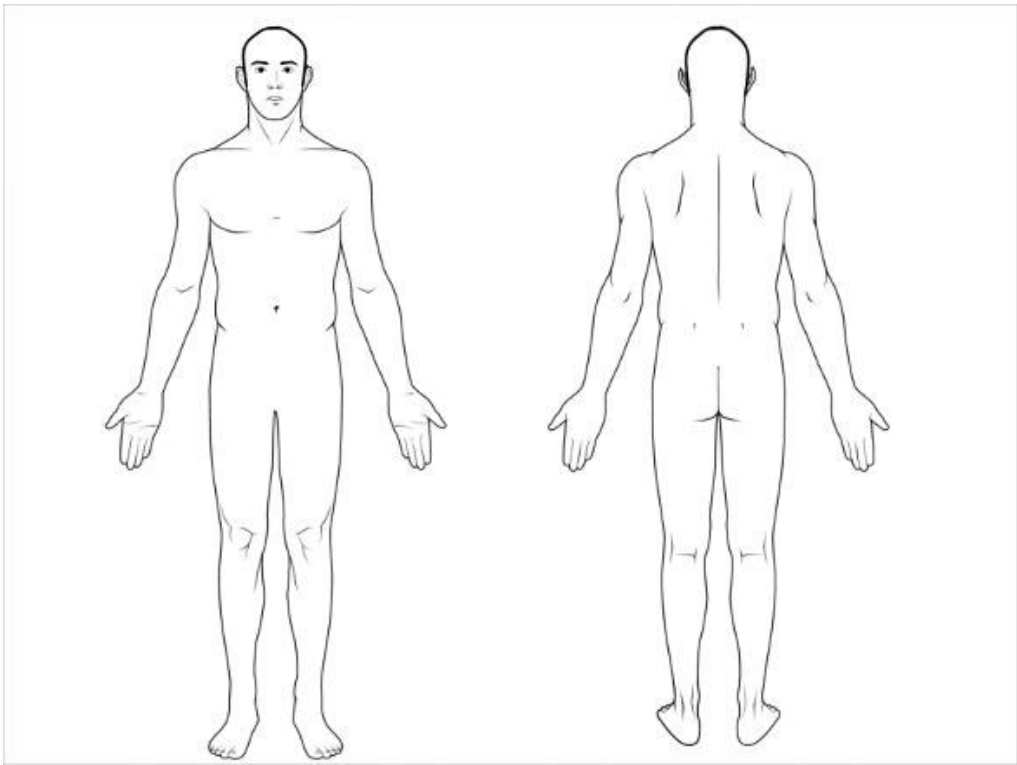
Mark the areas on the diagram below where you feel the described symptoms, using the appropriate symbol and include all affected areas.

Aching	Numbness	Pins and Needles	Sharp or Stabbing
^ ^ ^ ^	* * * * * *	o o o o o	/ / / /



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:

	In the morning		Constant
	During the day		With Activity
	At night		During rest

What makes the pain better?

_____

What are your goals for physical therapy?

_____

_____

_____

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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