



Please PRINT and fill out completely.

Date: ___/___/___
Name: _____ DOB: _____ Age: _____
Height ___ft. ___in. Weight _____lbs Sex: _____ Are you or could you be pregnant? _____
Your Occupation: _____ Employer: _____
Who referred you to this office? O Dr. _____ O PA/NP _____
O Family/Friend _____ O Physical Therapist _____
O Other _____
Pharmacy Name and Location: _____

HISTORY OF CARE

Who is your primary care physician? _____ Location: _____
Address: _____ Phone: _____
Please list any other doctors, clinics, or hospitals you have seen for your current spinal problems:
Name: _____ City: _____ Date of First Visit: _____ Currently Continuing?: _____

HISTORY OF CURRENT SPINAL PROBLEMS

List your chief complaints or main problems with the most severe first:
1. _____
2. _____
3. _____
Describe all details of any accident, incident or the way these problems began:

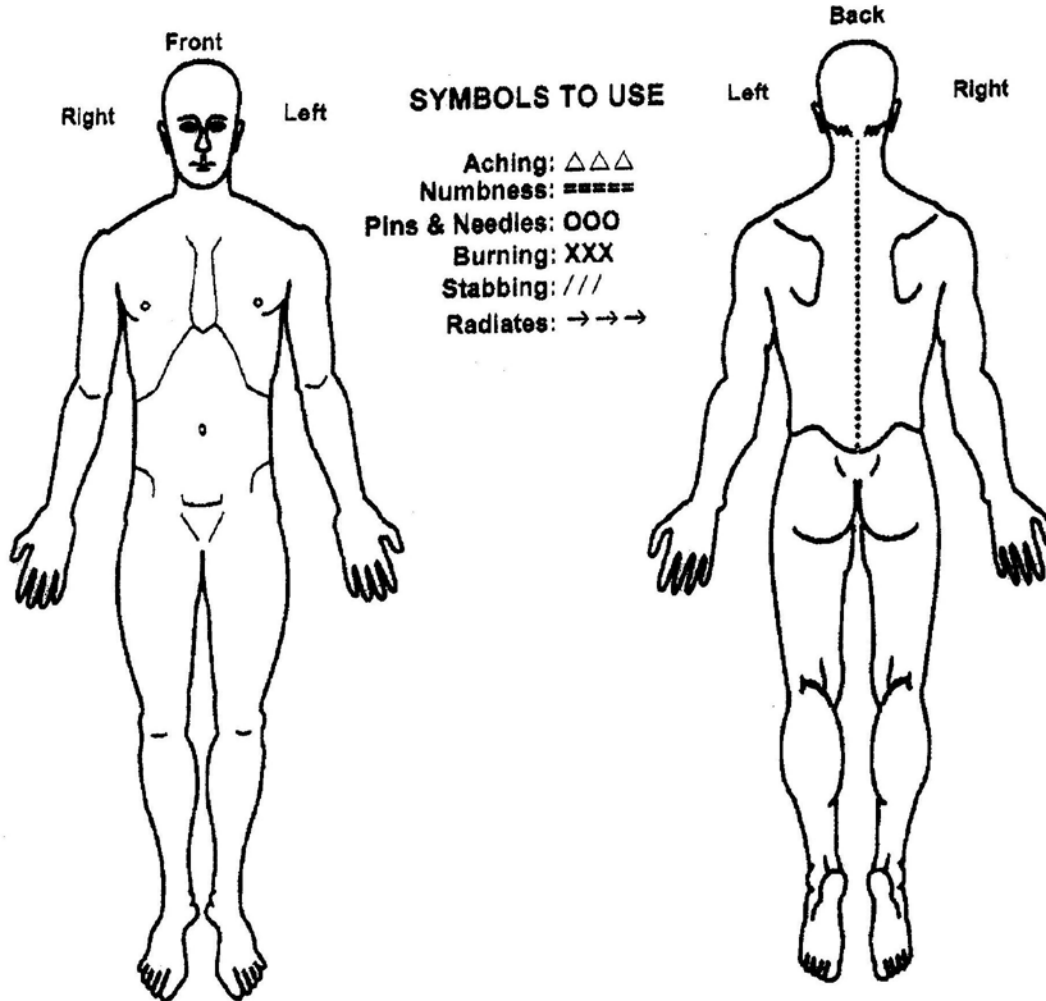
Is there current imaging available (i.e. MRI, CT) regarding this current spinal condition? _____
If so, at what facility was this performed? _____
Please bring a copy (CD or films) of your imaging to your appointment.

CURRENT SYMPTOMS

What time of day is your pain at its worst? O Morning O Afternoon O Evening O Night O N/A
Does the pain wake you up at night? O Yes O No
In the past six months have you experienced: O Fever O Weight Loss _____lbs
O Chills O Night Sweats
How would you describe your pain? O Constant O Constant, but worse with activity
O Intermittent (comes and goes)
O Intermittent, but worse with activity
Do you have full control of your bladder? O Yes O No
Do you have full control of your bowels? O Yes O No

PATIENT PAIN DRAWING

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, including all affected areas.



Mark where any symptoms (pain, numbness, weakness, etc) exist on average (most of the time) and at their worst.

	Current pain:										
	<u>None</u>									<u>Unbearable</u>	
Average	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10



MEDICAL HISTORY

Check if you are being treated for or have been diagnosed with:

	When?		When?
<input type="checkbox"/> High Blood Pressure	_____	<input type="checkbox"/> Osteoporosis	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Kidney Disease/Problem	_____
<input type="checkbox"/> Liver Disease	_____	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Heart Disease or Attack	_____	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Thyroid	_____
<input type="checkbox"/> Cancer	_____	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> High Cholesterol	_____	<input type="checkbox"/> Psoriasis	_____
<input type="checkbox"/> Ulcer Disease	_____	<input type="checkbox"/> Polio	_____
<input type="checkbox"/> Gastritis	_____	<input type="checkbox"/> Rheumatic Fever	_____
<input type="checkbox"/> Reflux Disease (GERD)	_____	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Herpes Simplex	_____
<input type="checkbox"/> Depression	_____	<input type="checkbox"/> Bipolar Disease	_____
<input type="checkbox"/> Other Psychiatric	_____	<input type="checkbox"/> *Pacemaker/ *Stent(s)	_____

* PLEASE PROVIDE CARD

Have you ever had a history of blood clots or pulmonary embolus? Yes No

SURGERIES

Please list all **spine** surgeries you have had in the past:

<i>Type of Surgery:</i>	<i>Date:</i>	<i>Surgeon:</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all **other** surgeries you have had in the past:

<i>Type of Surgery:</i>	<i>Date:</i>	<i>Surgeon:</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATIONS

Please list ALL medications you are **currently** taking, including prescription and over the counter:

<i>Medication:</i>	<i>Dosage :</i>	<i>Frequency: (how many pills in 24 hours)</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Please list any **allergies or adverse reactions** you have to medications:

<i>Medication:</i>	<i>What Happened?:</i>
_____	_____
_____	_____
_____	_____



FAMILY HISTORY

Is your father alive? Yes No IF YES, age and any major medical problems? _____
IF NO, age at time of death? _____ What major medical problems did he have? _____
Is your mother alive? Yes No IF YES, age and any major medical problems? _____
IF NO, age at time of death? _____ What major medical problems did she have? _____
Any siblings? Yes No How many? _____

SOCIAL HISTORY

Marital Status: Married Single Divorced Widowed Living with other
Do you have children? Yes No Ages: _____
Education level achieved: Grade School Jr. High High School College Post Graduate
DO you currently smoke cigarettes? Yes No Number of Years Smoked: _____ **FOR DR. USE:** P YRS _____
Packs per Day: (please choose the closest) < 1/2 1/2 1 2 >2
DID you smoke cigarettes in the past? Yes No Number of Years Smoked: _____ Quit Date: _____
Packs per Day: (please choose the closest) < 1/2 1/2 1 2 >2
Do you use any other tobacco products? Yes No What kind? _____ Quantity? _____
Do you use recreational drugs? Yes No What kind? _____
Do you drink alcohol? Yes No Drinks per Day _____ Drinks per Week _____
DO YOU OR HAVE YOU HAD an unhealthy relationship with alcohol? Yes No
Type of alcohol consumption: Beer Wine Mixed Drinks

WORK HISTORY

Are you currently: employed unemployed retired on sick leave on disability stay at home parent
Has your job changed since your symptoms started? Yes No Not working
If you are at a different job or not working, did your symptoms play a role in your job change or decision not to work? Yes No
If you are working, are you on: Normal duties Light duties
If you are on light duty, did your symptoms play a role? Yes No
Are you applying for disability? Yes No
Please describe your job: _____

WORKER'S COMPENSATION HISTORY

IS THIS A WORKERS COMPENSATION CASE? Yes No
Have you had any PRIOR workers compensation injuries? Yes No If yes, how many? _____
Please list any prior workers compensation cases/injuries:
Date: Area Injured: Time Off Work: Who Treated You?:

Were you at work when your symptoms began? Yes No
Did you have a specific accident or injury while at work to cause your symptoms? Yes No
What is the company name? _____
Prior to your WC injury, how long had you been employed by that company? _____
Do you currently have an attorney for this episode? Yes No



CAR ACCIDENTS

WERE YOUR SYMPTOMS CAUSED BY A CAR ACCIDENT? Yes No
Have you had any PRIOR car accidents? Yes No If yes, how many? _____
Please list: Date: Area Injured: Time Off Work: Who Treated You?:

Do you currently have an attorney for this episode? Yes No

REVIEW OF SYMPTOMS

Check Yes or No in the following areas. If "Yes," please describe:

1. CONSTITUTIONAL

- A. Recent Weight Change? Yes No _____
- B. Change or loss of appetite? Yes No _____
- C. Fevers? Yes No _____
- D. Chills? Yes No _____
- E. Night Sweats? Yes No _____
- F. Weakness/Fatigue? Yes No _____

2. EYES

- A. Vision change? Yes No _____
- B. Glasses/contacts? Yes No _____
- C. Glaucoma? Yes No _____
- D. Eye infections (iritis)? Yes No _____
- E. Loss of Vision? Yes No _____

3. EARS, NOSE AND THROAT

- A. Decrease or loss of hearing? Yes No _____
- B. Earache or infection? Yes No _____
- C. Tinnitus (ringing in ear)? Yes No _____
- D. Nasal stuffiness/discharge? Yes No _____
- E. Nosebleeds? Yes No _____
- F. Sore throat? Yes No _____
- G. Hoarseness? Yes No _____
- H. Dental problems? Yes No _____
- I. Dentures? Yes No _____
- J. Difficulty swallowing? Yes No _____

4. CARDIOVASCULAR

- A. Chest pain? Yes No _____
- B. Shortness of breath? Yes No _____
- C. Palpitations? Yes No _____
- D. Swelling in the legs? Yes No _____
- F. Pacemaker? Yes No _____

E. PLEASE LIST MOST RECENT HEART TESTS WITH NAME OF FACILITY, DATE, AND CONTACT PHONE NUMBER



5. RESPIRATORY

- A. Cough? Yes No _____
- B. Wheezing/asthma? Yes No _____
- C. Pneumonia or bronchitis? Yes No _____
- D. Shortness of breath? Yes No _____

6. GASTROINTESTINAL

- A. Abdominal pain? Yes No _____
- B. Nausea or vomiting? Yes No _____
- C. Constipation? Yes No _____
- D. Diarrhea? Yes No _____
- E. Heartburn/acid reflux? Yes No _____
- F. Rectal bleeding or black, tarry stools? Yes No _____

7. GENITOURINARY

- A. Increase frequency of urination? Yes No _____
- B. Pain/burning when you urinate? Yes No _____
- C. Frequent infection of urine? Yes No _____
- D. Incontinence (loss of control)? Yes No _____
- E. Reduced force of urination? Yes No _____

8. MUSCOLOSKELETAL

- A. Muscle aches? Yes No _____
- B. Joint pains/stiffness (arthritis)? Yes No _____
- C. Swelling of joints? Yes No _____

9. SKIN

- A. Rash? Yes No _____
- B. Lumps or sores? Yes No _____
- C. Changes in hair or nails? Yes No _____
- D. Dryness? Yes No _____
- E. Ulcers? Yes No _____
- F. Abnormal scars? Yes No _____

10. NEUROLOGICAL

- A. Headaches? Yes No _____
- B. Fainting/blackouts? Yes No _____
- C. Tremors/involuntary movements? Yes No _____
- D. Numbness, tingling? Yes No _____
- E. Dizziness? Yes No _____
- F. Muscle weakness? Yes No _____

11. PSYCHIATRIC

- A. Depression? Yes No _____
- B. Mood swings? Yes No _____
- C. Anger? Yes No _____
- D. Nervousness/anxiety Yes No _____

12. ENDOCRINE

- A. Excessive thirst or hunger? Yes No _____
- B. Hot/cold intolerance? Yes No _____
- C. Hot flashes? Yes No _____



13. HEMATOLOGICAL

A. Easy bruising or bleeding? Yes No _____

B. Past blood transfusions? Yes No _____

Patient Signature: _____ Date: _____

Additional comments:

Physician Signature: _____ Date: _____

FOR PHYSICIAN USE ONLY

Ht. _____ Wt. _____ RH. _____ LH. _____

A. Inspection:

Scoliosis
Kyphosis
Gibbus
Skin-café aulait
Scars

B. Posture:

Forward Head
Forward Shoulders
Lumbar Lordosis
Abd. Protrusion Pelvic Shift
Pelvic Obliquity

C. Palpation:

Masses
Drop-offs
Spasms
Facet Tenderness
Tender/Trigger Points

Quality of Movement-Lumbar-Pelvic Rhythm:

Provocative Maneuvers :

Forced Extension
Forced Extension w/ rotation L ____ R ____
Pelvic Rock Test L ____ R ____
Fabere L ____ R ____
Flip Test L ____ R ____
Piriformis Motor L ____ R ____
SLR L ____ R ____
Lasegue's L ____ R ____
Piriformis Stretch L ____ R ____
Gaenslen's Sign L ____ R ____
Femoral Stretch Test L ____ R ____

ROM:

Flexion (60)
Schober's Test
Extension (25)
Later Flexion L ____ R ____
Rotation L ____ R ____

