PATIENT MEDICAL HISTORY

Name _____ **Age** _____ **Date of Birth** _____ **Today's Date** _____
School (students only) _____ **Who referred you?** _____
Personal Physician _____ **Address** _____

What is the main problem for which you are seeking medical attention? _____
_____
_____
_____

Date of injury or pain onset ? _____ **Date you first sought medical attention?** _____
My joint pain has associated (circle any)? joint swelling locking/catching giving way buckling
Is this problem a result of (circle one)? MVA Personal Injury Sports Work Other
For Trauma: Driver ? Y / N **Passenger ?** Y / N **Aware of impending Impact or fall ?** Y / N
I braced for impact with my … body head right arm left arm right leg left leg
Please give details of how your pain/injury occurred: _____
_____
_____

List all previous medical provider(s) names seen & treatment(s) you have you tried for THIS problem?

	Who	Dates	Please Describe Imaging/Labs or Treatment given
ER			
PCP			
Specialist 1			
Specialist 2			
Specialist 3			
Manipulation			
Physical Therapy			
Medications			

What diagnostic studies have been done for THIS problem?

	Dates	Results		Dates	Results
X-rays			**MRI**		
Ultrasound			**CT Scan**		
Bone Scan			**other**		

CURRENT MEDICATIONS (including vitamins)	**ALLERGIES (describe reaction)**

Work Activity	
Job Description:	
Describe your activity level or any specific repetitive behaviors:	

Athletic / Sporting Activities		
	Amounts/Times per week	**Previous Injuries**
Sport 1:		
Sport 2:		
Sport 3:		

Do you currently smoke: _____ packs/day.
Have you ever smoked ? Y / N _____ packs/day. Year Quit _____.
Caffeine? _____ cups/day Alcohol? type _____ # Years amount _____

PAIN ASSESSMENT

How would you rate the SEVERITY of your pain on a BAD DAY or Time ? (circle all that apply):

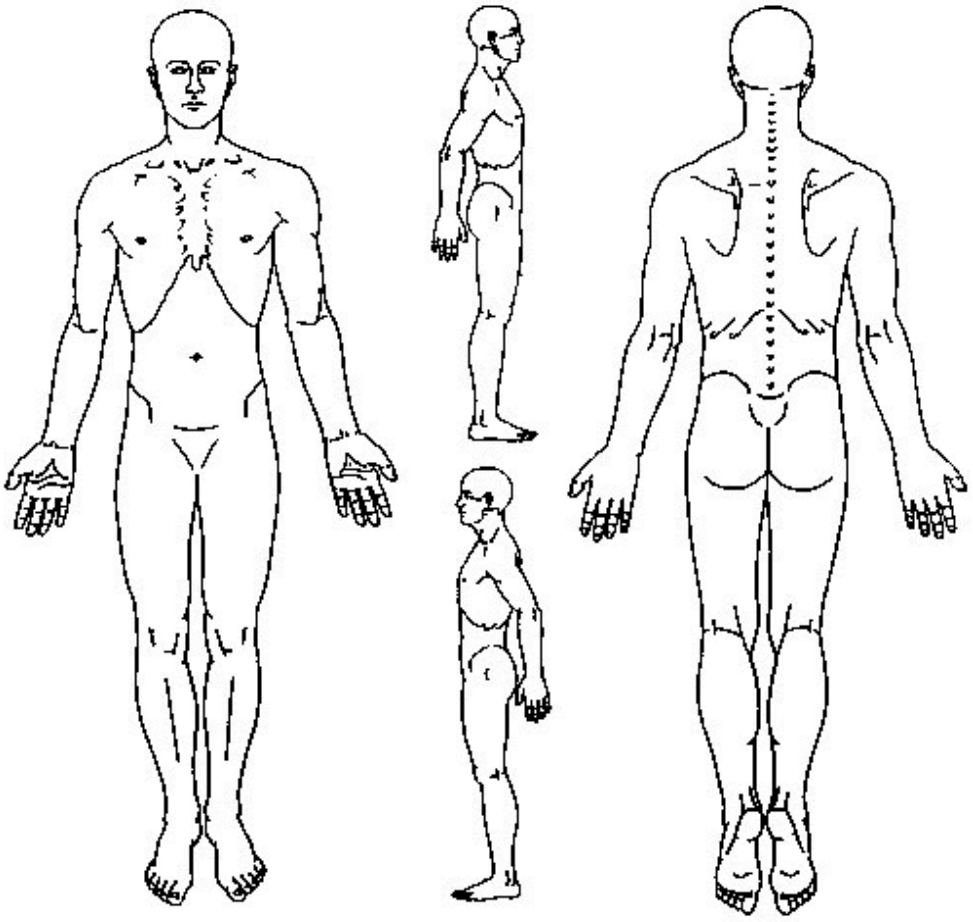
1 2	3 4	5 6	7 8	9 10
MILD PAIN	DISCOMFORTING	DISTRESSING	INTENSE	EXCRUCIATING
annoying	troublesome	miserable	dreadful / horrible	unbearable
nagging	irritating	agonizing	vicious	torturing
	numbing	gnawing	nauseating	crushing / tearing

How would you rate the SEVERITY of your pain on a GOOD DAY or Time ? (circle one):

1 2 3 4 5 6 7 8 9 10

Please indicate both the location and nature of your pain on the diagram below:

Numbness = = = Pins & Needles O O O Burning X X X Ache Λ Λ Λ Stabbing ///



Please rate your typical pain in these specific situations below: (circle closest response)

↑↑ = markedly increased
↑ = increased,
↓ = decreased,
↓↓ = markedly decreased

First thing AM: ↑↑ ↑ +/- ↓ ↓↓

Mid-day: ↑↑ ↑ +/- ↓ ↓↓

Evening: ↑↑ ↑ +/- ↓ ↓↓

Middle night: ↑↑ ↑ +/- ↓ ↓↓

Prolonged Sitting: ↑↑ ↑ +/- ↓ ↓↓

Prolonged Standing: ↑↑ ↑ +/- ↓ ↓↓

Walking: ↑↑ ↑ +/- ↓ ↓↓

Running: ↑↑ ↑ +/- ↓ ↓↓

Overall … my pain is getting (circle one): Getting Better Getting Worse Staying the Same

What makes your pain worse? _____

What makes your pain better? _____

How would you describe the QUALITY (NATURE or CHARACTER) of your pain ? (circle all apply)

lacerating		electrical	burning	aching	*intermittent*	throbbing	punishing
stinging	*deep*	shocking	shooting	heavy		pounding	pulling
sharp		cramping	flashing	hot	*variable*	aching	tugging
knife-like	*on surface*	squeezing	tingling	itching		numb	prickling
piercing		tight		cold	*constant*	tender	pins /needles

Does your pain or symptoms travel or radiate to other areas? Yes No (circle one)

If yes, describe … is the QUALITY and DEPTH of the pain different than the primary area ?

_____

_____

FAMILY HISTORY

	If Living		If Deceased	
	Age	Health Problems	Age	Cause of Death / Health Problems
Father				
Mother				
Brother(s)				
Sister(s)				

CURRENT MEDICAL PROBLEMS (FOR WHICH YOU ARE UNDER TREATMENT WITH OTHER PHYSICIANS)

HOSPITALIZATIONS AND SURGERIES

Date	Reason	Date	Reason

MEDICAL HISTORY (please CHECK all PRESENT conditions – "X" all PAST conditions):

HEENT		RESPIRATORY		MUSCULOSKELETAL	
Headaches		Asthma		Herniated Disc	
Migraines		Bronchitis		Location:	
Concussion		Pneumonia		Broken bones	
Head injury		Shortness of breath w/exercise		(specify)	
Eye problems		Coughing during / after exercise		Chronic back pain	
Wear glasses / contacts		Use an inhaler		Chronic neck pain	
- last eye exam:		**GASTRO-INTESTINAL**		Joint pain	
Hearing problems		Heartburn / indigestion		(specify):	
Sinus problems		Ulcers		Whiplash injury	
Frequent colds / illnesses		Diarrhea		Shoulder injury	
CARDIOVASCULAR		Constipation		Knee injury	
High blood pressure		Gall bladder problems		Sprained ankle	
Angina		Use antacids		Wear orthotics in shoes	
Chest pain with exertion		Hemorrhoids		Scoliosis	
Palpations		Irritable bowel		Tendonitis	
Irregular heart beat		Colitis / Crohn's disease		Bursitis	
Heart failure		Blood in stool/black tarry stool		Rheumatoid arthritis	
Get lightheaded / faint w/exercise		Diverticulosis / Diverticulitis		Degenerative arthritis	
Heart murmur		Excess gas / bloating		Short leg	
High cholesterol		**GENITOURINARY**		Osteoporosis	
Stroke		Frequent urinary infections		**ENDOCRINE**	
Aneurysm		Kidney stones		Diabetes (insulin-dependent)	
Phlebitis / blood clots in legs		Prostate trouble (men only)		Diabetes (non-insulin depend)	
Varicose veins		Burning while urinating		Hypothyroid (underactive)	
NEUROLOGICAL/PSYCHIATRIC		**FEMALE ONLY**		Hyperthyroid (overactive)	
Nerve injury (specify)		Age first menstrual period:		Gout	
		Age menopause:		Easily fatigued	
Anxiety		Frequency of periods:		**OTHER**	
Depression		Irregular menstrual cycles		Cancer	
Panic attacks		Irregular bleeding / spotting		Type:	
Dizziness		Frequent yeast infections		Anemia	
Convulsions / seizures		# of pregnancies			
Anorexia / Bulimia		# of deliveries			

PHYSICIANS NOTES: