

MEDICAL HISTORY FORM      DATE: \_\_\_\_\_      REFERRED BY: \_\_\_\_\_

NAME: \_\_\_\_\_      FAMILY DOCTOR: \_\_\_\_\_

NICK NAME: \_\_\_\_\_      AGE: \_\_\_\_\_      DOB: \_\_\_\_\_      Height: \_\_\_\_\_      Weight: \_\_\_\_\_

DATE **CURRENT** INJURY or SYMPTOMS began: \_\_\_\_\_       Right Handed       Left Handed

**IF INJURY, IS IT:**     work comp injury     motor vehicle accident     injured at home     sports injury

If car accident, were you the:     driver     front seat passenger     back seat passenger      Wearing seatbelt  Yes     No

PLEASE GIVE A **BRIEF DESCRIPTION** OF HOW THE INJURY OCCURRED:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

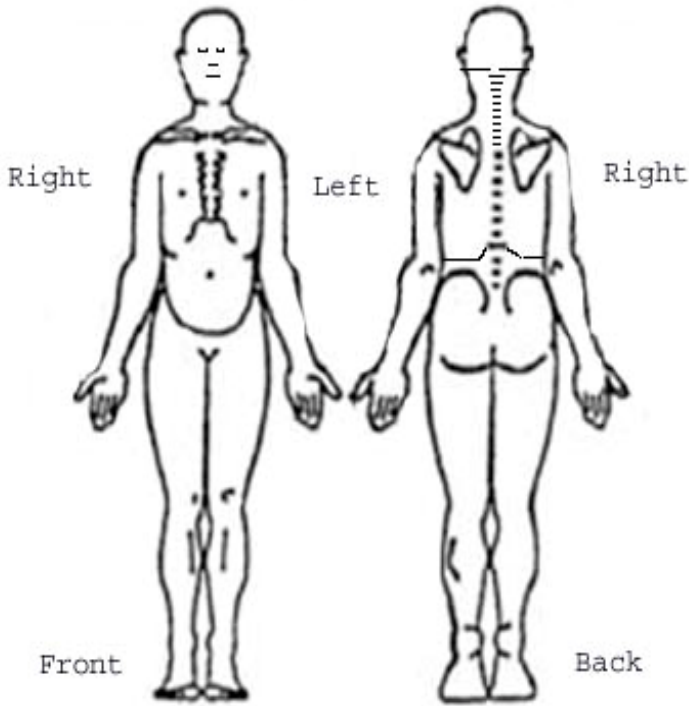
**PRIOR TO THIS INCIDENT**, have you had episodes of back pain in the past?     No     Back pain     Neck pain  
If so, when? \_\_\_\_\_      Was it work related?     Yes     No  
Are you currently working?     Yes     No     Retired     Disabled      Date you stopped working: \_\_\_\_\_

**Use the diagram below to show where your pain is located.**

Use the following symbols to describe the pain:  
**XX** = Burning    **///** = Stabbing    **NN** = Numb  
**ZZ** = Deep ache    **OO** = Pins/needles

**Rate your pain: 0 = no pain to 10 = worst you can imagine**

Right now:    0   1   2   3   4   5   6   7   8   9   10  
At worst:    0   1   2   3   4   5   6   7   8   9   10  
At best:    0   1   2   3   4   5   6   7   8   9   10  
The pain occurs:  
NECK PAIN:     intermittently     constantly     daily  
ARM PAIN:     intermittently     constantly     daily  
BACK PAIN:     intermittently     constantly     daily  
LEG PAIN:     intermittently     constantly     daily



Describe your symptoms (Example: I have constant burning pain in my low back with intermittent sharp, shooting pain down the left leg into my foot):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**How do the following activities affect your pain?**

	Better	Worse	No change
Bed rest	_____	_____	_____
Athletics (playing sports)	_____	_____	_____
Bending	_____	_____	_____
Changing body positions	_____	_____	_____
Coughing/sneezing	_____	_____	_____
Heat	_____	_____	_____
Ice	_____	_____	_____
Lifting	_____	_____	_____
Lying down	_____	_____	_____
Sitting	_____	_____	_____
Prolonged positions	_____	_____	_____
Standing	_____	_____	_____
Walking	_____	_____	_____
Working	_____	_____	_____
Exercising/stretching	_____	_____	_____
Riding in a car	_____	_____	_____

List anything else that improves or worsens pain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**TREATMENT:**  I have had no treatment for my neck / back problems to date.

I have had the following treatment for my back problems: (continued on next page)

**BRACE:**  have not used a back or neck brace  used a neck brace  used a low back brace

**BRACE RESULTS:**

- brace gave no significant relief  brace gave mild relief  
 brace gave significant but temporary relief  brace gave substantial relief

**PHYSICAL THERAPY:**  have never had physical therapy

I have been to physical therapy at (facility) \_\_\_\_\_

Approximate dates of physical therapy \_\_\_\_\_

**Treatment consisted of:**

- exercises  ultrasound  whirlpool  
 massage  electrical stimulation  phonophoresis  
 work hardening  diathermy  iontophoresis  
 ice  traction  triggerpoint ultrasound/cortisone  
 heat  TENS unit

**PHYSICAL THERAPY RESULTS:**

- therapy gave no significant relief  therapy gave mild relief  
 therapy gave significant but temporary relief  therapy gave substantial relief

**STEROID INJECTIONS:**  I have never had steroid injections of any type.

Date	Location (i.e. neck, low back, joint, caudal, trigger point)	X-ray guided? (yes / no)	Injection done by:	RESULTS OF INJECTION:				
				No Relief	Minimal Relief	Moderate Relief	Significant Relief	Made worse

**CHIROPRACTIC CARE**  I have not had chiropractic care.

I have had chiropractic care in the form of  manipulation  massage  x-rays  E-stim  acupuncture

Name of chiropractor: \_\_\_\_\_ Dates of treatment: \_\_\_\_\_

**CHIROPRACTIC RESULTS:**

- significant pain relief  temporary pain relief  no pain relief  made symptoms worse

**PAIN CLINIC:**  I have not attended a pain clinic.

Attended Pain Clinic at \_\_\_\_\_ Date of treatment: \_\_\_\_\_

**PAIN CLINIC RESULTS:**  no help  some help  significant help

**DIAGNOSTIC TESTING:**  I have not had any diagnostic testing to date

EMG – Date: \_\_\_\_\_  DEXA (bone density) – Date: \_\_\_\_\_  MRI / CT scan – Date: \_\_\_\_\_

**PAST MEDICATIONS USED:**  I have not tried either prescription or over-the-counter medications.

**MEDICATIONS TRIED INCLUDE:**

	Helped	No help		Helped	No help		Helped	No help
Advil	_____	_____	Flexeril	_____	_____	Avinza	_____	_____
Aleve	_____	_____	Skelaxin	_____	_____	Fenantyl patch	_____	_____
Ansaid	_____	_____	Soma	_____	_____	Kadian	_____	_____
Cataflam	_____	_____	Vistaril	_____	_____	Lortab (hydrocodone)	_____	_____
Celebrex	_____	_____	Zanaflex	_____	_____	Oxycontin	_____	_____
Daypro	_____	_____		_____	_____	Percocet (Oxycodone)	_____	_____
Feldene	_____	_____	Amitriptyline	_____	_____	Tylenol w/ Codeine	_____	_____
Ibuprofen	_____	_____	Cymbalta	_____	_____	Tylox	_____	_____
Indocin	_____	_____	Elavil	_____	_____	Ultram (tramadol)	_____	_____
Lodine	_____	_____	Paxil	_____	_____	Vicodin (hydrocodone)	_____	_____
Mobic	_____	_____	Prozac	_____	_____		_____	_____
Motrin	_____	_____	Xanax	_____	_____	Medrol Dosepak	_____	_____
Relafen	_____	_____	Zoloft	_____	_____	Prednisone	_____	_____
Voltaren	_____	_____		_____	_____		_____	_____
	_____	_____	Lyrica	_____	_____		_____	_____
Tylenol	_____	_____	Neurontin	_____	_____		_____	_____

**PREVIOUS SPINE SURGERY:**  I have never had surgery on my back.

**PREVIOUS SPINE SURGERY #1:**

Date of surgery: \_\_\_\_\_ Surgeon (name/address): \_\_\_\_\_  
Hospital: \_\_\_\_\_ in (city/state) \_\_\_\_\_  
Reason for surgery \_\_\_\_\_  
Surgery performed: \_\_\_\_\_  
Results:  Pain free  Very good  Good  Some help, but still problems  No change

**PREVIOUS SPINE SURGERY #2:**

Date of surgery: \_\_\_\_\_ Surgeon (name/address): \_\_\_\_\_  
Hospital: \_\_\_\_\_ in (city/state) \_\_\_\_\_  
Reason for surgery \_\_\_\_\_  
Surgery performed: \_\_\_\_\_  
Results:  Pain free  Very good  Good  Some help, but still problems  No change

**PREVIOUS SPINE SURGERY #3:**

Date of surgery: \_\_\_\_\_ Surgeon (name/address): \_\_\_\_\_  
Hospital: \_\_\_\_\_ in (city/state) \_\_\_\_\_  
Reason for surgery \_\_\_\_\_  
Surgery performed: \_\_\_\_\_  
Results:  Pain free  Very good  Good  Some help, but still problems  No change

**At this time, I am receiving the following treatment:**

- rest and activity modification
- symptomatic treatment including heat and/or ice
- using a cane, walker or wheelchair (circle the one you are using)
- physical therapy
- steroid injections
- wearing a brace
- work restrictions and/or light duty: \_\_\_\_\_

**PREVIOUS/ONGOING MEDICAL PROBLEMS:**

- None
- Asthma
- Bronchitis
- Blood clot
- Cancer: \_\_\_\_\_
- Constipation
- Depression
- Diabetes
- Diarrhea
- Emphysema
- Gastroesophageal reflux
- Gout
- Heart: \_\_\_\_\_
- Hypertension / High blood pressure
- High cholesterol
- Kidney disease
- Migraines
- Osteoporosis
- Parkinson's
- Pulmonary disease
- Prostate problems
- Ulcers
- Other: \_\_\_\_\_

**LIST ALL THE MEDICATIONS YOU CURRENTLY TAKE:**

None

<u>Drug name:</u>	<u>Dose:</u>		
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day
_____	_____ mg	_____	_____ times a day

**Over the Counter/herbal medicine/vitamins:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PREVIOUS SURGERIES:**

- Appendectomy
- Biopsy of \_\_\_\_\_  Left  Right  Benign  Malignant
- Cardiac: \_\_\_\_\_
- Carpal tunnel  Right  Left  Bilateral
- Cataract  Right  Left  Bilateral
- Gallbladder
- Hip replacement  Right  Left  Bilateral
- Hysterectomy  Uterus only  Uterus/ovaries
- Knee arthroscopy  Right  Left  Bilateral
- Knee replacement  Right  Left  Bilateral
- Mastectomy  Right  Left  Bilateral
- Prostatectomy  Partial  Total
- Radiation Therapy: \_\_\_\_\_
- Thyroidectomy
- Tonsillectomy
- Other: \_\_\_\_\_

**CHILDHOOD DISEASE:**  Chickenpox  Measles  Mumps  Pertusis  Polio  Rheumatic fever  Scarlet fever

**ALLERGIES:**  No known Drug Allergies

I am allergic to the following medication:  penicillin  sulfa  codeine  morphine  aspirin  demerol

other: \_\_\_\_\_  
It causes:  rash  shortness of breath  vomiting  nausea  swelling  other: \_\_\_\_\_

**FAMILY HISTORY: (parents/siblings)**  Unknown  I have no family history of heart disease, cancer or other serious illnesses.

Heart disease: (what kind & who has it) \_\_\_\_\_

Cancer: (what kind & who has it) \_\_\_\_\_

Other: \_\_\_\_\_

**SOCIAL HISTORY:**

Education:  GED  Graduated high school  Some college  Graduated college  Trade school

Military service:  Yes  No  Branch: \_\_\_\_\_ How long? \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ How long? \_\_\_\_\_

Previous employer: \_\_\_\_\_ How long? \_\_\_\_\_

Marital status:  Single  Married  Divorced  Separated  Widowed Number of children: \_\_\_\_\_

Do you use nicotine products?  No, never have  
 Yes How much? # \_\_\_\_\_  pack  can  cigar  Nicotine gum/patch per day for \_\_\_\_\_ years  
 No, I stopped on \_\_\_\_\_ How much did you use? \_\_\_\_\_  pack  can  cigar per day for \_\_\_\_\_ years

Alcohol:  None  # \_\_\_\_\_ drinks per day / week / month (circle one)  Previous user

Caffeine:  None  Minimal  Moderate  Heavy

Exercise:  Not at all  Daily  Weekly (# per week: \_\_\_\_\_)  Occasionally Type: \_\_\_\_\_

Diet:  No specific  Diabetic  Low fat  Low salt  Vegetarian  Weight reduction

**REVIEW OF SYSTEMS:** Check any of the following symptoms you are currently experiencing:

No further complaints

**ALLERGY:**  hay fever  environmental allergies  chronic immunity problems

**GENERAL:**  fever  sweats  chills  decreased energy/activity level  
 major weight gain  major weight loss  change in appetite

**HEENT:**  runny nose  nose bleeds  sinus congestion/pain  ringing in ears  
 hearing loss (do you wear a hearing aid  yes  no)  vision changes (do you wear  contacts  glasses)

**CARDIAC:**  chest pain  heart palpitations  tachyarrhythmia  difficulty breathing  
 lightheaded  dizziness

**ENDOCRINE:**  excessive thirst  excessive urination  heat intolerance  
 diabetes  thyroid problems  cold intolerance

**GI:**  abdominal pain  abdominal bloating  vomiting  heartburn  reflux  
 constipation  diarrhea  bowel incontinence  bloody stools

**GU:**  urinary incontinence  urinary frequency/urgency  erectile dysfunction  pain with urination  
 prostate problems  vaginal problems  postmenopausal  irregular menstrual cycles  
 post hysterectomy

**HEMA/LYMPH:**  anemia  easy bruising  swollen nodes

**MUSC/SKEL:**  joint inflammation  joint restriction  joint pain  back pain  
 muscle pain  muscle swelling  neck pain

**NEURO:**  poor balance  poor coordination  limp  drag/slap foot  seizure disorder  
 paralysis  numbness  weakness in any extremity (  arm  leg )

**PSYCH:**  stress  depression  sleep disturbance  mood changes

**RESPIRATORY:**  snoring  sleep apnea  recent upper respiratory infection  
 wheezing  cough  blood stained sputum

**SKIN:**  rash  birth marks  discoloration of the skin  non-healing skin lesions

Have you had a complete physical exam in the last 12 months?  No

Date of last physical exam was on \_\_\_\_\_ by Dr. \_\_\_\_\_ Revised 7/2008