

Medical Information

Name: _____ Date: _____

Handedness: (Circle) Right Left Both

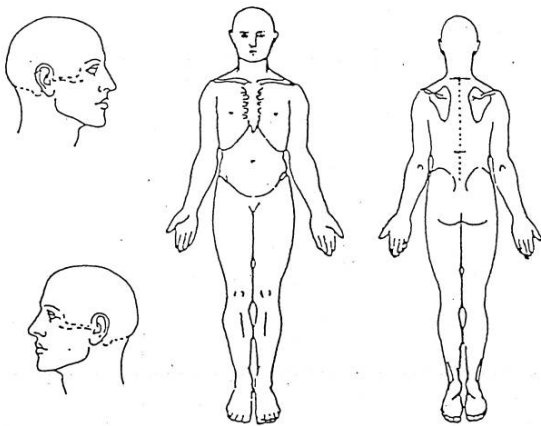
Date of Injury: _____ Referral Source: _____

Date of surgery: _____ Physician: _____

1. Briefly describe your reasons for seeking therapy (e.g. symptoms, type of injury):

2. What are your treatment goals?:

3. Mark pain location (see below) on body chart with X's, and mark numbness with /// :
shooting pains with ->



4. Place three circles on the scale below to indicate the intensity of pain/discomfort at its best, on average, and at its worst.

0 1 2 3 4 5 6 7 8 9 10
no painminimal.....moderate.....severeworst pain imaginable

5. Describe pain (check all that apply):

Sharp Dull Burning Ache Shooting
 Tingling Numb Stabbing Pressure Radiating
 Other (please describe): _____

6. Are your symptoms constant or intermittent? (Circle one)

If intermittent, how often do they occur?: _____

Are you getting better, worse or staying the same? (circle one)

7. What positions or activities increase your pain or symptoms?

8. What positions or activities decrease or relieve your pain or symptoms?

9. Have you seen any other health practitioners for this same or similar condition? If so, please list below the name, title, approximate dates, and type of treatment. Were these treatments beneficial?

10. Have you had any of the following tests performed for this problem?

Please give dates and results.

Xray _____ EEG: _____ EMG : _____

CT scan: _____ MRI: _____ Arthrogram: _____

Bone scan: _____ Other: _____

11. List all current medications & supplements (including over-the-counter medications, vitamins, herbs, homeopathic remedies). Use back of sheet or separate sheet, if needed.

12. Estimate your usual intake of the following:

Caffeine _____ cups/day Cigarettes _____ packs/day

13. Please check all conditions that apply to you (now or in past):

- | | |
|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Head injuries |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart condition |
| <input type="checkbox"/> Appetite or weight changes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Intestinal/digestive problems |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Jaw pain or chewing problems (TMJ) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Blackouts | <input type="checkbox"/> Learning disabilities |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Bowel/bladder problems | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Blood pressure (high/low) | <input type="checkbox"/> Neck or back injuries |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Orthodontics or major dental work |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Pregnancy/childbirth |
| <input type="checkbox"/> COPD (respiratory) | <input type="checkbox"/> Ringing in ears (tinnitus) |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Sinus problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Dislocations | <input type="checkbox"/> Swallow problems |
| <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Teeth clenching or grinding |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Thyroid problem (high or low) |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Other |

14. Comments: (Please elaborate as needed, on above conditions)

15. List major injuries and surgeries below (include date):
