Patient Medical History Form

Demographics:

1. Last Name: ____________________ First Name: ______________________ Middle Initial: _______
2. Date of Birth: ___/___/____
3. Gender (Please place an “X” next to your selection): Male: ____ Female: ____
4. Race/Ethnicity (Please select one): African American: ____ Asian: ____ Caucasian (White): ____ Eskimo/Inuit: ____ Hispanic/Latino: ____ Native American: ____ Other: ____ Declined: ____
5. Education Level (Please select the highest level attained): No high school diploma: ____ High school graduate or GED: ____ Some college no degree: ____ Occupation/technical/vocational school: ____ Associate degree: ____ Bachelor’s degree: ____ Master’s Degree: ____ Professional school degree (e.g. M.D. or J.D.): ____ Doctoral degree (e.g. Ph.D): ____ Declined: ____ Unknown: ____
6. Employment Status: Working now: ____ Looking for work, unemployed: ____ Sick leave or maternity leave: ____ Disabled permanently or temporarily due to the condition you are receiving treatment for: ____ Disabled for other reasons: ____ Student: ____ Temporarily laid off: ____ Retired: ____ Keeping house: ____ Other, Specify: __________________________

Social History:

7. How would you rate your general health? Excellent: ____ Good: ____ Fair: ____ Poor: ____
8. How limited is your ability to participate in social activities? Severely: ____ Moderately: ____ Minimally: ____ Normal: ____
9. How limited is your ability to participate in recreational activities? Severely: ___ Moderately: ___ Minimally: ___ Normal: ___
10. How would you describe your smoking status/tobacco use? Never smoked/used tobacco: ___ Current user: ___ Quit: ___
    1. Current users: How long have you smoked? __________ How many packs per day? __________
11. In the past year, have you drunk or used drugs more than you meant to? Never: ___ Rarely: ___ Sometimes: ___ Often: ___
12. Have you felt you wanted/needed to cut down on your drinking/drug use? Never: ___ Rarely: ___ Sometimes: ___ Often: ___
13. Do you perform 150 minutes of moderately strenuous or 75 minutes of vigorous exercise/physical activity a week? Yes / No
14. How would you describe your nutritional habits? Very poor: ____ Poor: ____ Fair: ____ Good: ____ Very good: ____
15. In the past 7 days, my sleep quality was: Very poor: ____ Poor: ____ Fair: ____ Good: ____ Very good: ____
16. During the past month, have you been bothered by feeling down, depressed or hopeless? Yes: ____ No: ____
17. During the past month, have you had little interest or pleasure in doing things? Yes: ____ No: ____
18. Do you have any barriers to learning? Yes: ____ No: ____ If yes, please explain: ____________________________________

Current History:

19. What date (approximately) did your present symptoms start? _____________________________________
20. Have you ever experienced these symptoms before? Yes: ___ No: ___ If yes, when? ________________________________
21. How did your present symptoms begin (e.g. gradually, suddenly, injury)? ____
22. How have your symptoms changed? Getting better: ____ About the same: ____ Getting worse: ____
23. Have you seen a medical professional for your present symptoms? Yes: ___ No: ____ If yes, who? _____________________
24. Have you had an x-ray, MRI, or other testing for this problem? Yes: ___ No: ___ Please specify: _______________________

25. What treatments have you received for this problem so far? ____

26. Please list the medications you are currently taking for this problem: ____

27. Are you experiencing any of the following symptoms? (Please circle all that apply):

Fever/chills/sweats	Dizziness	Nausea/vomiting	Night pain
Numbness/tingling	Poor balance (Falling)	Unexplained weight loss	Severe headaches
Depression	Shortness of breath	Difficulty swallowing	Pelvic pain
Difficulty urinating/voiding			

Past Medical History:

28. Have you ever been told you have any of the following?

Cancer	Yes	No	Ulcers	Yes	No	Diabetes	Yes	No
Heart problems	Yes	No	Infectious diseases	Yes	No	Osteoporosis	Yes	No
High Blood Pressure	Yes	No	Lung problems	Yes	No	Thyroid problems	Yes	No
Angina/Chest Pain	Yes	No	Hepatitis	Yes	No	Rheumatoid arthritis	Yes	No
Asthma	Yes	No	Anemia	Yes	No	Osteoarthritis	Yes	No
Fibromyalgia	Yes	No	Allergies	Yes	No	Depression	Yes	No
Kidney disease	Yes	No	Stroke	Yes	No	Seizures/Epilepsy	Yes	No

Other: _________________________________

29. List any other injuries you have had that required medical attention: ____

30. Please list any additional medications unrelated to your present complaint that you are currently taking:

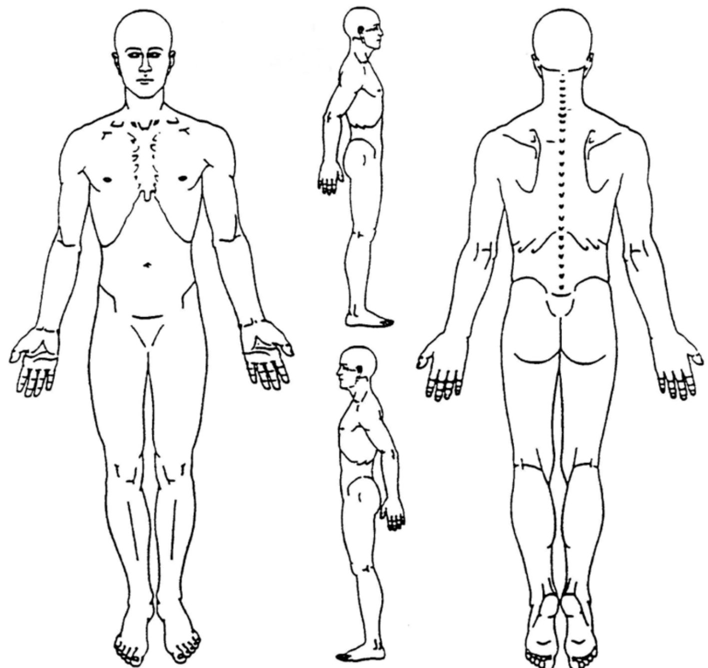
____________________________ ______________________________ ______________________________

____________________________ ______________________________ ______________________________

Symptom Location and Behavior:

Body Diagram: Please shade (color), circle, and label the location(s) of your symptom(s) on the diagram to the right following the directions listed below.

1. *Shade (color)* in the areas in which you are feeling **<u>Pain.</u>**
2. *Circle* the areas in which you are feeling **<u>tingling, prickling, or burning.</u>**
3. *Label* the area(s) with a **"N"** in which you feel **<u>numbness, heaviness, or other.</u>** *Label* the area(s) **"S"** in which you feel **<u>sudden/stabbing pain.</u>** *Label* the area(s) **"P"** in which you feel **<u>pressure.</u>**



31. On the scale below, circle the number which best represents the average level of pain you have experienced over the last 7 days:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain you have ever experienced

32. On the scale below, circle the number which best represents the best level of pain you have experienced in the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain you have ever experienced

33. On the scale below, circle the number which best represents the worst level of pain you have experienced in the last 24 hours:

0 1 2 3 4 5 6 7 8 9 10

No Pain — Worst pain you have ever experienced

34. Is light touching (e.g. clothing, a blanket) in this area painful?

Never: ___ Hardly noticeable: ___ Slightly: ___ Moderately: ___ Strongly: ___ Very strongly: ___

35. Is cold or heat (e.g. bath water) in this area painful?

Never: ___ Hardly noticeable: ___ Slightly: ___ Moderately: ___ Strongly: ___ Very strongly: ___

36. Identify up to 3 important activities that you are unable to do or are having difficulty performing as a result of your problem. Using the scale below, score how difficult it is for you to do the activities you identified.

0 1 2 3 4 5 6 7 8 9 10

Unable to Perform — Able to perform activity at the same level as before injury or problem

1. ___________________________________ Score: ______
2. ___________________________________ Score: ______
3. ___________________________________ Score: ______

37. What are your personal goals for therapy at this time?

1. ____
2. ____
3. ____

CONSENT: My diagnosis and treatment plan will be discussed during my appointment and I understand that I have the right to question and/or refuse any treatment offered. The information I have provided above is accurate and complete. __________________________________ ____________________

(Signature) (Date)