

Medical History

To ensure you receive a complete and thorough evaluation, please provide us with the most accurate, important, and up to date background information.

Name: _____ Age: _____ Occupation: _____

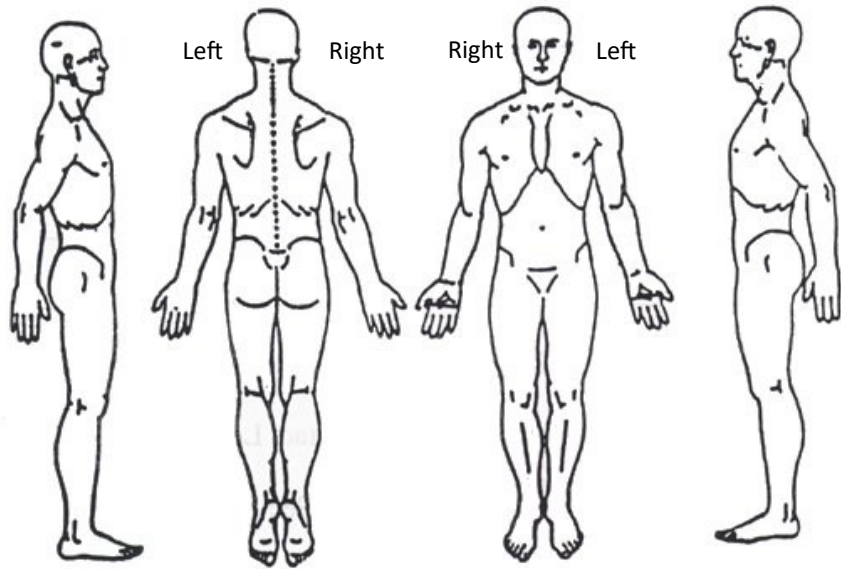
1) What do you think caused your symptoms?: _____

2) Please list special tests performed on this problem (x-ray, MRI, lab): _____

3) Have you ever had this problem before? _____ When? _____ Treatment rec'd? _____
 If yes, how long did it take for you to feel better? _____

Instructions: Please mark on the diagram to the right to indicate where you feel symptoms right now.

4) Please describe your Symptoms:



<p>5) My symptoms are currently:</p> <p><input type="checkbox"/> Getting Better</p> <p><input type="checkbox"/> Getting Worse</p> <p><input type="checkbox"/> Staying about the same</p>	<p>6) My symptoms currently:</p> <p><input type="checkbox"/> Come and go</p> <p><input type="checkbox"/> Are constant</p> <p><input type="checkbox"/> Constant, but change with activity</p>	<p>7) Currently, are you able to sleep due to symptoms?</p> <p><input type="checkbox"/> No problem sleeping</p> <p><input type="checkbox"/> Difficulty falling asleep</p> <p><input type="checkbox"/> Awakened by pain</p> <p><input type="checkbox"/> Sleep only with medication</p>
<p>8) When are your symptoms worst?</p> <p><input type="checkbox"/> Morning <input type="checkbox"/> Afternoon</p> <p><input type="checkbox"/> Evening <input type="checkbox"/> Night</p> <p><input type="checkbox"/> After exercise</p>	<p>9) When are your symptoms best?</p> <p><input type="checkbox"/> Morning <input type="checkbox"/> Afternoon</p> <p><input type="checkbox"/> Evening <input type="checkbox"/> Night</p> <p><input type="checkbox"/> After exercise</p>	<p>10) At the present time, would you say your health is:</p> <p><input type="checkbox"/> Excellent <input type="checkbox"/> Good</p> <p><input type="checkbox"/> Fair <input type="checkbox"/> Poor</p>

<p>11) Aggravating Factors: Identify up to 3 important positions or activities that make symptoms worse:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p>12) Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>	<p>13) What are your goals for therapy?</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>
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14) Using the 0 to 10 scale, with 0 being no pain and 10 being the worst pain imaginable please describe:

Your current level of pain while completing this survey: _____

The best your pain has been the past 24 hours _____

The worst your pain has been the last 24 hours _____

15) Personal health history (check all that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Neurological disease | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke or TIA | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Anxiety or Panic Disorder |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD), ARDS, or emphysema | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hepatitis, TB, HIV, Aids |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes– Type I and II | <input type="checkbox"/> Prosthesis/ Implants |
| <input type="checkbox"/> Congestive heart failure (or heart disease) | <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Seizures | <input type="checkbox"/> Latex allergy |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Visual Impairment | <input type="checkbox"/> Have a pacemaker |
| | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Pregnant |
| | <input type="checkbox"/> Back Pain/ Neck Pain | <input type="checkbox"/> Smoker |
| | <input type="checkbox"/> Kidneys, bladder, prostate issues | <input type="checkbox"/> Other: _____ |
| | <input type="checkbox"/> Previous accidents | |

16) Have you recently experienced the following?

- | | | |
|--|---|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fainting | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Fever/chills/sweats | <input type="checkbox"/> Difficulty maintaining balance while walking | <input type="checkbox"/> Bowel or bladder changes |
| <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Falls | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Weightloss/gain | <input type="checkbox"/> Dizziness/ Lightheadedness | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Heartburn/Indigestion | <input type="checkbox"/> Cough |
| | | <input type="checkbox"/> Headaches |

17) Over the last 2 weeks how often have you been bothered by any of the following problems:

- Feeling down, depressed or hopeless? Bothered by, have little interest or pleasure in doing things?
- Is this something with which you would like help?** Yes Yes, but not today No

18) Medications: This includes prescriptions, over the counter drugs, herbal and nutritional supplements. Separate list provided? Yes No **If not, please complete the section below.**

Medication/Drug Supplement/Vitamin:	Dosage:	Route of Administration:	Is this a Prescription?	Frequency Per Day:

19) Please list any recent surgeries or hospitalizations including dates:

20) Other:

- Are you currently in a Skilled Nursing Home? No Yes
- Are you receiving any Home Health Services? No Yes
- Is injury a result of a fall in the past year? No Yes
- Have you fallen 2 or more times in the past year? No Yes

21) Are you covered:

- | | | |
|---------------------------|----|-----|
| Under Black Lung Disease? | No | Yes |
| End Stage Renal Disease? | No | Yes |
| Large Group Insurance? | No | Yes |
| Veterans Affairs? | No | Yes |