PATIENT INFORMATION RECORD

Name____

Referring Physician____________________ Diagnosis____________________

Home phone #____________________ Cell phone #____________________

Occupation____________________ Age____________________

Date injury occurred____________________ How did injury occur?____________________

What activities could you perform before, that you cannot now because of your injury?____________________

____

Do you have any symptoms of tingling, burning or numbness? Yes No

Any changes in bowel/bladder functions? Yes No

What activities make your symptoms worse?____________________

What makes your symptoms better?____________________

Do your symptoms change throughout the day?____________________

Have you had similar episodes before?____________________

Are these episodes increasing in frequency? Severity? Character?____________________

What is the usual cause for recurrent injuries?____________________

Have you had surgery for this injury?____________________

Have you been treated or are you currently being treated by any other health care practitioner for these symptoms? Yes No

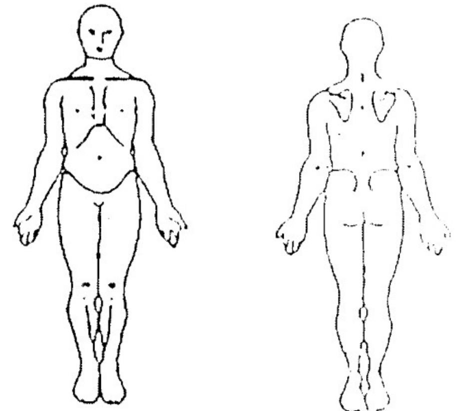
If so, who are they?____________________

Have you had any recent diagnostic test performed, regarding you present injury (x-rays, MRI, etc.) ? Yes No

If so, what are they and when were they performed?____________________

Medical History

Please indicate the location of your symptoms on the diagram



pain
numbness
tingling
shooting pain

What medications are you taking, if any?____________________

What allergies do you have, if any?____________________

Question		
Do you have a history of diabetes?	Yes	No
Do you have a history of heart disease?	Yes	No
Do you have a history of high blood pressure?	Yes	No
Is it under control?	Yes	No
Have you had previous head trauma or repeated convultions?	Yes	No
Have you had surgery for your head, neck or spine?	Yes	No
Have you had any abdominal surgeries?	Yes	No
Have you had any previous shoulder injuries?	Yes	No
Have you had any previous knee injuries?	Yes	No
Have you had any previous ankle injuries?	Yes	No
Have you had any fractures?	Yes	No
Are you currently pregnant?	Yes	No
Have you been diagnosed with osteoporosis?	Yes	No
Have you been diagnosed with rheumatoid arthritis?	Yes	No
Do you have a personal history with cancer?	Yes	No
Do you have glaucoma?	Yes	No

What sports/exercise do you play at least 3 times a week?____________________

Do you exercise regularly, at least 3 times a week?____________________

Do you know of any reason why you should not participate in a regular exercise program?

____

Is there any other medical condition or diagnosis we should be aware of?

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Signature____________________ Date____/____/____