PATIENT MEDICAL HISTORY

Name: _____ Date of birth: _____ Height: _____Weight:_____

Referring Physician: _____ Primary care Physician: _____

Occupation: _____ Leisure activities, recreation, exercise: _____

Please tell us about your current symptoms:

When did your symptoms start? (Injury/surgery)_____

How did your symptoms start? Gradual / traumatic / sudden / specific event / unsure

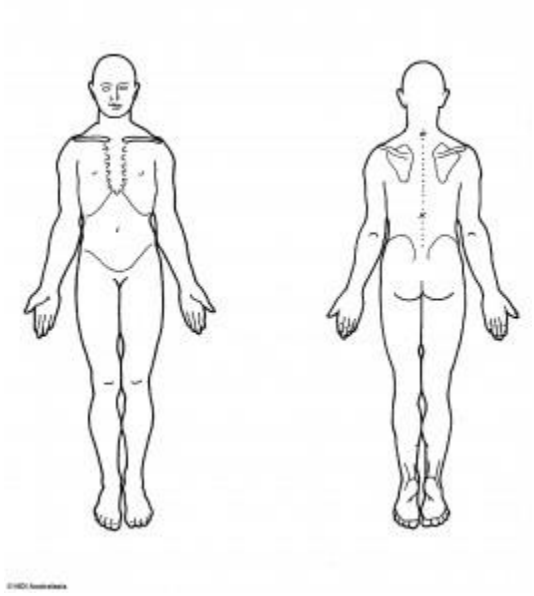
What do you think is causing your symptoms? _____

Have you had an x-ray, MRI, or other investigations done for your current problem? _____

My symptoms are currently: getting better / staying the same / getting worse

Have you previously received any treatment for this problem? Was it helpful? _____

Please draw your symptoms on the chart below:



For the therapist:

+/- cough/sneeze

+/- Saddle anesth

+/- Bowel/bladder

+/- Numb/ting

Using the scale below, please indicate the number which best represents the severity of your pain:

No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain imaginable**

Currently: ____ Best for the last 48 hours: ____ Worst for the last 48 hours: _____

What activities make your symptoms worse? _____

What makes your symptoms better? _____

What are your goals/expectations from therapy? _____

Do you currently take anti-inflammatories? Muscle relaxants? Pain medications? Please list all current medications (or attach list): _____

Have you ever taken steroid medications for any medical condition? YES/NO

Have you ever taken blood thinning/anticoagulation medication? YES/NO

Please list surgical history: _____

Smoker? YES/NO Pregnant (confirmed or suspected) YES/NO

Have you recently noted any of the following? (Please check all that apply)

❑ Fatigue	❑ Muscle weakness	❑ Changes in bowel/bladder function
❑ Fever/chills/sweats	❑ Shortness of breath	❑ Headaches
❑ Nausea/vomiting	❑ Fainting	❑ Pain with menstruation
❑ Numbness/tingling	❑ Difficulty swallowing	❑ Cough
❑ Poor balance/falls, dizziness	❑ Heartburn/indigestion	❑ Unexplained weight loss/gain
❑ Pain with/after eating	❑ Increased pain at night/rest/sleeping difficulty	❑Visual disturbances

Past Medical History: (Have you ever had, or have you ever been diagnosed with any of the following?)

❑ Cancer	❑ Pacemaker	❑ Migraines
❑ Heart disease, angina, chest pains, heart surgery	❑ Allergies/asthma	❑ Have you had recent illness/infection?
❑ High blood pressure	❑ Lung disease	❑ Bowel or bladder problems
❑ Anemia	❑ Kidney disease	❑ Osteoporosis
❑ Blood clot	❑ Liver disease	❑ Diabetes
❑ Stroke/TIA	❑ Ulcers	❑ Seizures/epilepsy
❑ History of infectious disease	❑ Thyroid disease	❑ Fibromyalgia
❑ Osteoarthritis	❑ Multiple sclerosis	❑ Circulation problems
❑ Rheumatoid arthritis	❑Use of immunosuppressant drugs	❑ Emotional/psychological problems (incl. depression)

Does anyone in your immediate family have a history of: (Please circle) Cancer; Heart problems; High blood pressure; Diabetes; Stroke; Depression; Thyroid problems; Blood clots

During the past month, have you often been bothered by feeling down, depressed or hopeless? YES/NO

During the past month, have you been bothered by little interest or pleasure in doing things? YES/NO

Is this something with which you would like help? YES, TODAY/ YES, NOT TODAY/ NO

Please list any other information that may assist us with your care: _____

_____

Patient signature: _____ Date: _____

Therapist reviewed: _____ Cardiac screen: BP: _____HR: _____