

Past Medical History

STAFF ONLY

Patient Identification Number	Date: MM/DD/YYYY	Payer Source	Patient Proxy, if applicable
Primary Clinician	Body Part	Multi <input type="checkbox"/>	Impairment Category
			Multi <input type="checkbox"/>
Patient Name (Last Name, First Name)	Birth Date: MM/DD/YYYY	Male <input type="checkbox"/>	Female <input type="checkbox"/>

PATIENT PORTION

1. How many days ago did this condition begin?

0-7 8-14 15-21 22-90 91-6 mo. More than 6 mo.

2. Date of injury: _____

3. Date of next physician's visit: _____

4. Have you had a related injury?

Yes No

5. Have you ever had these symptoms before?

Yes No

6. Height _____

7. Weight _____

8. If female, are you pregnant? Yes No

9. What is your present employment status? (Mark ONE response only)

- | | |
|---|-------------------------------------|
| <input type="checkbox"/> Employed-presently working full duty at same job | <input type="checkbox"/> Unemployed |
| <input type="checkbox"/> Employed-presently working full duty at different job | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Employed-presently working restricted duty at same job | <input type="checkbox"/> Student |
| <input type="checkbox"/> Employed-presently working restricted duty at different job | <input type="checkbox"/> Other |
| <input type="checkbox"/> Employed-presently not working due to my condition | |
| <input type="checkbox"/> Previously employed-receiving disability benefits for my condition | |

10. Indicate the number of surgeries for your primary condition: 0 1 2+

11. Have you received treatment for this condition before? Yes No

If yes, what type of treatment did you have? _____

12. How often have you completed at least 20 minutes of exercise such as jogging, cycling, or brisk walking, prior to the onset of your condition?

At least 3 times/week Once or twice/week Seldom or never

13. I should not do physical activities which might make my pain worse:

0- Completely disagree 1 2 3-Unsure 4 5 6- Completely Agree

14. Please indicate the average pain you have had in the last 24 hours by circling the number:

No Pain _____ As bad as it can be
 0 1 2 3 4 5 6 7 8 9 10

15. Are you taking prescription medication for this condition? Yes No

16. Please list ANY medications you take and what they are for: _____

17. Please list any known allergies: _____

Lower Back

18. In relation to why you are being seen in therapy, please check the activities that are difficult for you to perform:

- Bathing Writing Bending Sitting Lifting Urine Control Bladder Control
 Standing Driving Gripping Cooking Pinching Climbing Steps Sexual Relations
 Reaching Walking Sleeping Dressing Computer Work
 Wheelchair Propulsion Other _____

Please answer these more specific questions to help us take better care of you. **If you do not do or have not done these activities, please make your best guess as to which response is the most accurate.**

Today, how much difficulty do/would you have...	I Can't Do This	Much Difficulty	Some Difficulty	Little Difficulty	No Difficulty
Performing any of your usual work or school activities?					
Performing your usual hobbies, recreational or sporting activities?					
Performing heavy activities around your home?					
Bending or stooping?					
Are you or would you be limited by:			Limited A Lot	Limited A Little	Not Limited At All
Vigorous activities like running, lifting heavy objects, participating in strenuous sports?					
Moderate activities like moving a table, pushing a vacuum cleaner, bowling or playing golf?					
Lifting or carrying items like groceries?					
Attending social events?					
Getting in and out of a chair?					

19. Other health problems may affect your treatment. Please check any of the following that apply:

- | | | |
|---|--|--|
| <input type="checkbox"/> Arthritis (Rheumatoid/Osteo) | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pain interferes with sleep |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Asthma/Breathing Difficulties | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Fractures |
| <input type="checkbox"/> COPD, ARDS or Emphysema | <input type="checkbox"/> GI Disease (Ulcer, Hernia (Reflux, Bowel, Liver Gall Bladder) | <input type="checkbox"/> Skin Abnormalities |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Visual Impairment (Cataracts, Glaucoma, Macular Degeneration) | <input type="checkbox"/> Anxiety/Panic Disorders |
| <input type="checkbox"/> Congestive Heart Failure (or Heart Disease) | <input type="checkbox"/> HOH, even with hearing aids | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart Attack (or MI) | <input type="checkbox"/> Ringing in your ears | <input type="checkbox"/> Other Disorders |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Diabetes Type I or II | <input type="checkbox"/> Hepatitis/AIDS |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Prior Surgery |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Back Pain (Neck, DDD, or Spinal Stenosis) | <input type="checkbox"/> Prosthesis/Metal Implants |
| <input type="checkbox"/> Neurological Disease (such as MS or Parkinson's) | <input type="checkbox"/> Kidney, Bladder, Prostate or Urination Problems | <input type="checkbox"/> Sleep Dysfunction |
| <input type="checkbox"/> Stroke or TIA | | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Peripheral Vascular Disease | | <input type="checkbox"/> Smoking |
| | | <input type="checkbox"/> Changes in bowel/bladder function |

Please add any details if you checked any of the above, and/or list any other pertinent information: _____

By signing this form, I acknowledge that the information is true and accurate to the best of my understanding.

Patient Signature _____

Date _____

Witness Signature _____

Date _____