

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: _____

Shoulder

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
Combing/brushing your hair using your affected arm?					
Using your affected arm to place a can of soup (1 lb) on a shelf at shoulder height?					
Using your affected arm to pick up and drink out of a full water glass?					
Using your affected arm to reach a shelf at shldr height?					
Using your affected arm to reach an overhead shelf?					
Pushing yourself out of a chair using both arms?					
Reaching for a salt shaker at the table while sitting?					
Getting a scarf or necktie over your head and around your neck, using both hands?					
Putting on deodorant under the arm opposite your affected arm?					
Pulling a chair out from a table using your affected arm?					

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 _____