PATIENT INFORMATION RECORD

Name________________________ Social Security #________________________

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?________________________

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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?________________________

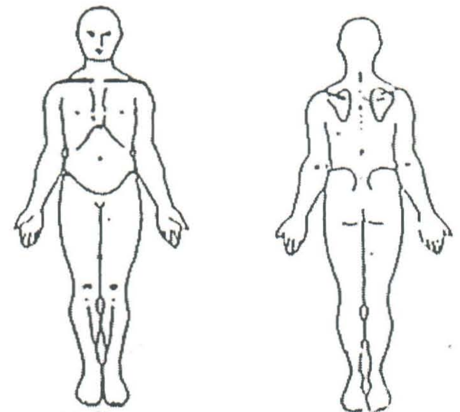
Medical History

Please indicate the location of your symptoms on the diagram.

What medications are you taking, if any?________________________

What allergies do you have, if any?________________________

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



pain
numbness
tingling
shooting pain

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_____/______/______