

# 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? \_\_\_\_\_

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? \_\_\_\_\_

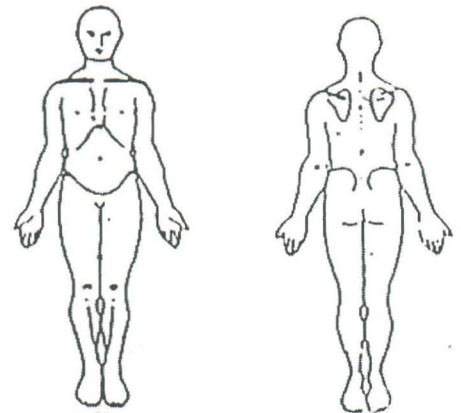
## Medical History

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 convulsions?	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? \_\_\_\_\_

Please indicate the location of your symptoms on the diagram.



pain  
 numbness  
 tingling  
 shooting pain

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

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_