

PATIENT INFORMATION RECORD

Name _____

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

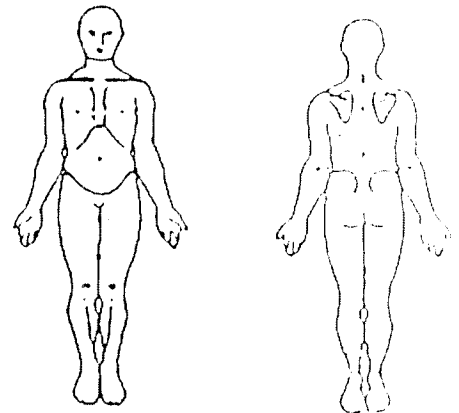
Do you have glaucoma? Yes No

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 ____/____/____