

Precision Sport & Spine

Patient Name: _____

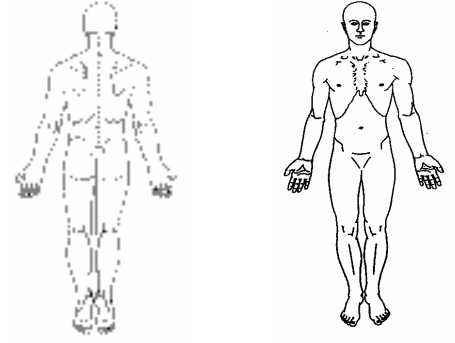
Date: _____

Chief Complaint #1: Neck / Low Back / Mid-Back - Other: _____

• Mark **Area of Discomfort** on Drawing ----->

• When did the **last episode** of your symptom appear?

• Did anything **contribute to the onset** of your condition?



• Is your condition getting progressively worse, better or same? _____

• Is your condition worse in the A.M / P.M. / All the Time / Doesn't Apply? _____

• **Interferes** with Work / Seep / Daily Routine / Other: _____

• **Describe** your Discomfort: Sharp with Movement / Sharp when Not Moving / Dull / Throbbing / Aching / Shooting / Numbness / Burning / Tingling / Cramping / Stiffness / Swelling – Other: _____

• Does your discomfort **radiate or travel** (For example: from neck to shoulder)? If so where: _____

• **Rate the severity** of your discomfort (1 = minimal and 10 = severe pain) Now: _____ At its worst: _____

• **How many days** out of an average week do you have pain? _____

What percentage of the time do you feel your discomfort? 0-25% 26-50% 51-75% 76-100%

• **Activities** or movements that are painful or **aggravate** your condition: Sitting / Standing / Walking / Bending / Lying Down Getting Dressed / Sports / Work / Hobbies (please list) / Everything - Other: _____

• What **activities, movements, make your condition feel better?** _____

• Have you had the **exact same condition?** Yes / No If so when? _____

List other Physicians or Therapist seen for this condition in chronological order from most recent:

Physician	Date	Outcome of Visit (diagnostic test, treatment, diagnosis)
_____	_____	_____
_____	_____	_____
_____	_____	_____

• List treatments you have received for this condition:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Body Mechanics Training | <input type="checkbox"/> Chiropractic | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Massage | <input type="checkbox"/> Strengthening Exercises | <input type="checkbox"/> Osteopathic Care | <input type="checkbox"/> Trigger Point Inject. |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Aerobics | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> TENS Unit | <input type="checkbox"/> Gravity Inversion – Traction | <input type="checkbox"/> Naturopathy | |
| <input type="checkbox"/> Bed Rest | <input type="checkbox"/> Biofeedback | <input type="checkbox"/> Back Brace | |

Additional Notes (For Office Use) _____

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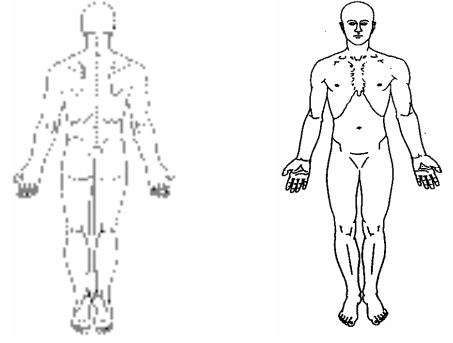
Date: _____

Chief Complaint # 2 : Neck / Low Back / Mid-Back - Other: _____

• Mark **Area of Discomfort** on Drawing ----->

• When did the **last episode** of your symptom appear?

• Did anything **contribute to the onset** of your condition?



• Is your condition getting progressively worse, better or same? _____

• Is your condition worse in the A.M / P.M. / All the Time / Doesn't Apply? _____

• **Interferes** with Work / Seep / Daily Routine / Other: _____

• **Describe** your Discomfort: Sharp with Movement / Sharp when Not Moving / Dull / Throbbing / Aching / Shooting / Numbness / Burning / Tingling / Cramping / Stiffness / Swelling – Other: _____

• Does your discomfort **radiate or travel** (For example: from neck to shoulder)? If so where: _____

• **Rate the severity** of your discomfort (1 = minimal and 10 = severe pain) Now: _____ At its worst: _____

• **How many days** out of an average week do you have pain? _____

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• What **activities**, movements, make your condition **feel better**? _____

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_____	_____	_____
_____	_____	_____

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| <input type="checkbox"/> Massage | <input type="checkbox"/> Strengthening Exercises | <input type="checkbox"/> Osteopathic Care | <input type="checkbox"/> Trigger Point Inject. |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Aerobics | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> TENS Unit | <input type="checkbox"/> Gravity Inversion – Traction | <input type="checkbox"/> Naturopathy | |
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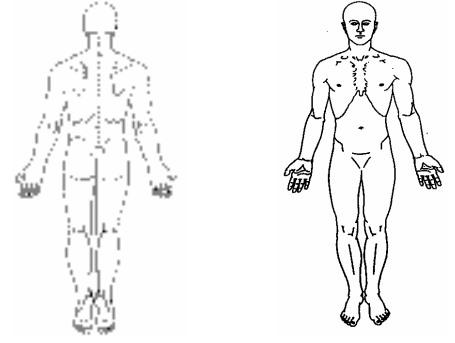
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Chief Complaint # 3: Neck / Low Back / Mid-Back - Other: _____

• Mark **Area of Discomfort** on Drawing ----->

• When did the **last episode** of your symptom appear?

• Did anything **contribute to the onset** of your condition?



• Is your condition getting progressively worse, better or same? _____

• Is your condition worse in the A.M / P.M. / All the Time / Doesn't Apply? _____

• **Interferes** with Work / Seep / Daily Routine / Other: _____

• **Describe** your Discomfort: Sharp with Movement / Sharp when Not Moving / Dull / Throbbing / Aching / Shooting / Numbness / Burning / Tingling / Cramping / Stiffness / Swelling – Other: _____

• Does your discomfort **radiate or travel** (For example: from neck to shoulder)? If so where: _____

• **Rate the severity** of your discomfort (1 = minimal and 10 = severe pain) Now: _____ At its worst: _____

• **How many days** out of an average week do you have pain? _____

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_____	_____	_____
_____	_____	_____

• List treatments you have received for this condition:

- | | | | |
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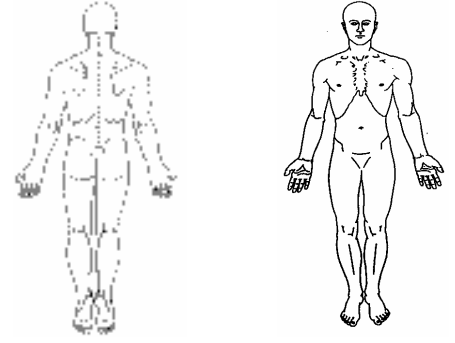
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Chief Complaint #4: Neck / Low Back / Mid-Back - Other: _____

• Mark **Area of Discomfort** on Drawing ----->

• When did the **last episode** of your symptom appear?

• Did anything **contribute to the onset** of your condition?



• Is your condition getting progressively worse, better or same? _____
• Is your condition worse in the A.M / P.M. / All the Time / Doesn't Apply? _____

• **Interferes** with Work / Seep / Daily Routine / Other: _____

• **Describe** your Discomfort: Sharp with Movement / Sharp when Not Moving / Dull / Throbbing / Aching / Shooting / Numbness / Burning / Tingling / Cramping / Stiffness / Swelling – Other: _____

• Does your discomfort **radiate or travel** (For example: from neck to shoulder)? If so where: _____

• **Rate the severity** of your discomfort (1 = minimal and 10 = severe pain) Now: _____ At its worst: _____

• **How many days** out of an average week do you have pain? _____

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• List treatments you have received for this condition:

- | | | | |
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| <input type="checkbox"/> Massage | <input type="checkbox"/> Strengthening Exercises | <input type="checkbox"/> Osteopathic Care | <input type="checkbox"/> Trigger Point Inject. |
| <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Aerobics | <input type="checkbox"/> Acupuncture | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> TENS Unit | <input type="checkbox"/> Gravity Inversion – Traction | <input type="checkbox"/> Naturopathy | |
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Additional Notes (For Office Use) _____

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Patient Name: _____ Date: _____

Social History

- [] Single [] Smoker
[] Married [] Non-Smoker
[] Divorced [] Drinks Alcohol
[] Does not drink Alcohol
[] Takes Drugs

List your Hobbies

Water: _____ cups /oz per day Caffeine: _____ cups / sodas per day

Sleep Pattern

How many hours of uninterrupted sleep do you experience? _____ Hours

How is your sleep? (Circle: restful, restless, hard to get to sleep, wake up often)

Exercise

What kind of exercise do you do? _____

How often? _____ How long at a time? _____

Occupational History

Job Title _____ Job Demands _____

Occupation Demands:

- Sitting _____ Hours per day
Standing _____ Hours per day
Walking _____ Hours per day
Lifting _____ Hours per day

Stress Level

Rate your stress level from 1-10 (10 being the highest and 1 the lowest stress level)

_____ / 10

What is the main reason for your stress level? _____

Medications/Traumas

Please list medications you are taking:

Vitamins or Herbs:

Injuries / Surgeries you have had. Please give description and approximate date

Motor Vehicle Accidents:

Any Falls:

Head Injuries:

Broken Bones:

Surgeries or Hospitalization: (State approximate dates)

Other serious injuries or health problems:

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Date: _____

Medical Conditions – List any current or previous condition(s): (List approximate date of previous condition)

<u>Medical Condition</u>	<u>Previously</u>	<u>Currently</u>
Heart Attack/Stroke	_____	[]
High Blood Pressure	_____	[]
Other Heart Condition	_____	[]
Fainting/Seizures	_____	[]
Easy Bruising / Bleeding	_____	[]
<hr/>		
Difficulty Breathing	_____	[]
Chest Pain/Tightness	_____	[]
Coughing Up Blood	_____	[]
Persistent Cough	_____	[]
Emphysema/COPD	_____	[]
Asthma	_____	[]
<hr/>		
Excessive Fatigue	_____	[]
Difficulty Sleeping	_____	[]
Unusual Stress at Work	_____	[]
Unusual Stress at Home	_____	[]
Anxiety	_____	[]
Depression	_____	[]
Irritability	_____	[]
<hr/>		
Unexplained Fever	_____	[]
Night Sweats	_____	[]
Weight Loss 10 lbs or more	_____	[]
Loss of Appetite	_____	[]
Lumps in neck, armpit, groin	_____	[]
Cancer	_____	[]
<hr/>		
Stomach Pain	_____	[]
Persistent Diarrhea	_____	[]
Excessive Constipation	_____	[]
Dark Black Stools	_____	[]
Blood in Stools	_____	[]
Colitis	_____	[]
Ulcers	_____	[]

<u>Medical Condition</u>	<u>Previously</u>	<u>Currently</u>
Do you have a bowel movement daily?	Yes	No
How many days do you skip between bowel movements when you are not regular?	_____	days
• How often does this occur?	_____	

Frequent Neck Pain	_____	[]
Jaw Pain	_____	[]
Severe, Frequent Headaches	_____	[]
Shoulder Pain	_____	[]
Wrist Pain or Carpel Tunnel	_____	[]
Hip Pain	_____	[]
Low Back Pain	_____	[]
Knee Pain	_____	[]
Ankle Pain	_____	[]
Feet Pain	_____	[]
Artificial Bones/Joints	_____	[]
<hr/>		
Pain when urinating	_____	[]
Difficulty urinating	_____	[]
Blood in Urine	_____	[]
Need to Urinate at Night	_____	[]

Hepatitis	_____	[]
Kidney Problems	_____	[]
HIV Positive, AIDS	_____	[]
Diabetes	_____	[]
Gout	_____	[]

<u>Females Only</u>		
Vaginal Bleeding	_____	[]
Other than Period	_____	[]
Painful Menstrual Period	_____	[]
Back Pain with Menstrual Period	_____	[]

Other Menstrual Problems: _____