FK RH NC OM GW SM EH
Form 1 - Revised: 06/15/2010

Initial History

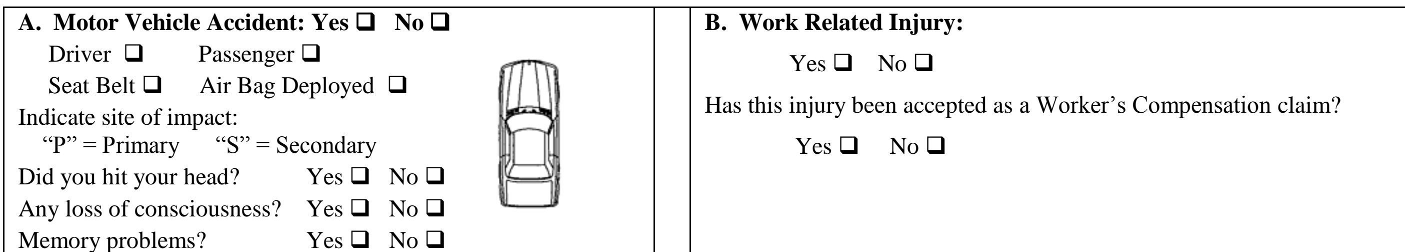
Name: ____ **Date:** ____/____/_____

DOB: ____/____/____ Please provide the following medical information to the best of your ability.

CHIEF COMPLAINT: What is the main reason for your visit? ____

____

1. Date of your accident/injury? ___________________________ (If neither one skip to "C" below)



A. Motor Vehicle Accident: Yes ❑ No ❑ Driver ❑ Passenger ❑ Seat Belt ❑ Air Bag Deployed ❑ Indicate site of impact: "P" = Primary "S" = Secondary Did you hit your head? Yes ❑ No ❑ Any loss of consciousness? Yes ❑ No ❑ Memory problems? Yes ❑ No ❑		**B. Work Related Injury:** Yes ❑ No ❑ Has this injury been accepted as a Worker's Compensation claim? Yes ❑ No ❑

C. Describe your accident/injury or history of problem in detail.

____

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2. Have your symptoms gotten…. Worse ❑ Better ❑ Same ❑ (check only one)

3. Your present pain is…. Constant ❑ Intermittent ❑ Worse in the… A.M. ❑ P.M. ❑

4. What activities increase your pain? Sitting ❑ Standing ❑ Walking ❑ Lifting ❑ Housework ❑ Coughing/Sneezing ❑ Lying flat on back ❑ Lying flat on stomach ❑

5. What activities decrease your pain?
Sitting ❑ Standing ❑ Walking ❑ Lying flat on back ❑ Lying flat on side with knees bent ❑

6. Are you: Right-Handed ❑ Left-Handed ❑

7. Do you have any pain going down your arm or leg… ❑ No ❑Yes (if "yes" circle the area involved)

Right Arm Left Arm Right Leg Left Leg

Do you have any numbness/tingling down your arm or leg… ❑ No ❑Yes (if "yes" circle the area involved)

Right Arm Left Arm Right Leg Left Leg

Do you have any weakness of your arm or leg… ❑ No ❑Yes (if "yes" circle the area involved)

Right Arm Left Arm Right Leg Left Leg

8. Do you have difficulty sleeping because of pain? Yes ❑ No ❑

9. Have any other physicians evaluated you for this problem? Yes ❑ No ❑

If yes, who/when? ____

10. Have any tests (x-rays, CT scan, MRI) been done to evaluate this problem? Yes ❑ No ❑

If yes, please describe and give the facility name: ____

Reviewed By Initials _____

Initial History (cont'd) **Name: ____Date _____/_____/______**

11. What treatments have you received? Please describe (ex: PT, Chiro, Surgery)

____________________________ Made Better ❑ Worse ❑ No Change ❑
____________________________ Made Better ❑ Worse ❑ No Change ❑
____________________________ Made Better ❑ Worse ❑ No Change ❑

12. Have you had any previous accident, injury or problems with your neck, back, shoulders, or knees?

Yes ❑ No ❑ If yes, please describe where and when: ____
____
____

13. Pain Medications that you are taking now:
List all your pain medicines including any that are over-the-counter such as Tylenol, Aleve, etc.

Name	Does it help?	Side effects?
	Yes ❑ No ❑	
	Yes ❑ No ❑	
	Yes ❑ No ❑	

14. Pain Medications that you have taken in the past:

Name	Did it help?	Side effects?
	Yes ❑ No ❑	
	Yes ❑ No ❑	
	Yes ❑ No ❑	

15. All other regular medicines if any: (ex: for blood pressure, diabetes, ulcers, blood thinners)
(Please include any over-the-counter drugs, eye drops, vitamins, etc.)

Name	For how long?	Side effects?

16. Drug allergies:

❑ Aspirin ❑ Sulfa drugs ❑ Novocain/Lidocaine ❑ Iodine Dye ❑ Penicillin ❑ Shellfish ❑ Latex

❑ Other: (write medicine name and reaction) ❑ No Known Drug Allergy

17. Past Medical History - Please check the "Yes" or "No" box if you have any of the following illnesses; for "Yes" answers, please explain.

Diabetes Yes ❑ No ❑______________________
Hypertension (high blood pressure) Yes ❑ No ❑______________________
Heart Disease Yes ❑ No ❑______________________
High Cholesterol Yes ❑ No ❑______________________
Respiratory problems Yes ❑ No ❑______________________
Stomach/Intestinal problems Yes ❑ No ❑______________________
Bleeding Disorder Yes ❑ No ❑______________________

Thyroid problems Yes ❑ No ❑______________________
Allergy problems/Therapy Yes ❑ No ❑______________________
Kidney/Bladder/Prostate problems Yes ❑ No ❑______________________
Neurological problems Yes ❑ No ❑______________________
Addiction or Substance Abuse Yes ❑ No ❑______________________
Mental Health/Psychiatric Yes ❑ No ❑______________________
Other medical diagnosis Yes ❑ No ❑______________________

18. Past Surgical History: (Please list all surgeries)

Type of Surgery	When & Name of Surgeon

Reviewed By (Initials) _________

Initial History(cont'd) **Name:** ______________________________________ **Date** ____/____/_____

19. Review of systems:

a. Please check the "Yes" or "No" box if you have any of the following symptoms.
b. Check the "Current" box if this symptom relates to the reason for your visit today.

		Yes	No	Current		Yes	No	Current
GENERAL	Chills	☐	☐	☐	Weight Loss or Gain	☐	☐	☐
	Fatigue	☐	☐	☐	Daytime Sleepiness	☐	☐	☐
ALLERGY	Environmental	☐	☐	☐	Sneezing fits	☐	☐	☐
NEURO	Passing out	☐	☐	☐	Seizures	☐	☐	☐
	Weakness	☐	☐	☐	Numbness/tingling	☐	☐	☐
	Memory loss	☐	☐	☐	Abnormal ache	☐	☐	☐
EYES	Eye pain/pressure	☐	☐	☐	Vision Changes	☐	☐	☐
ENT	Ringing in ears	☐	☐	☐	Dizziness	☐	☐	☐
	Hearing loss	☐	☐	☐	Sinus pain	☐	☐	☐
	Snoring	☐	☐	☐	Sore throat	☐	☐	☐
RESPIRATORY	Cough	☐	☐	☐	Coughing Blood	☐	☐	☐
	Wheezing	☐	☐	☐	Shortness of breath	☐	☐	☐
CARDIAC	Chest Pain	☐	☐	☐	Palpitations	☐	☐	☐
	Wake short of breath	☐	☐	☐	Ankle Swelling	☐	☐	☐
GASTRO - INTESTINAL	Difficulty Swallowing	☐	☐	☐	Heartburn	☐	☐	☐
	Abdominal Pain	☐	☐	☐	Nausea/Vomiting	☐	☐	☐
	Bowel Irregularity	☐	☐	☐	Rectal Bleeding	☐	☐	☐
GENITOURINARY	Frequent Urinating	☐	☐	☐	Painful Urination	☐	☐	☐
	Blood in urine	☐	☐	☐	Prostate Problems	☐	☐	☐
	Loss of bladder control	☐	☐	☐	Is there a chance you are pregnant?	☐	☐	☐
HEME/LYMPH	Swollen glands	☐	☐	☐	Sweating at night	☐	☐	☐
	Bleeding problems	☐	☐	☐	Easy Bruising	☐	☐	☐
ENDOCRINE	Feel warmer than others	☐	☐	☐	Feel cooler than others	☐	☐	☐
MUSCULOSKEL	Joint pain/stiffness	☐	☐	☐	Cramps	☐	☐	☐
	Muscle ache	☐	☐	☐	Weakness	☐	☐	☐
	Loss of mobility	☐	☐	☐				
DERMATOLOGIC	Rash	☐	☐	☐	Hives	☐	☐	☐
	Itching	☐	☐	☐	Skin or Hair changes	☐	☐	☐
MENTAL HEALTH	Nervousness	☐	☐	☐	Tension	☐	☐	☐
	Mood changes	☐	☐	☐	Depression	☐	☐	☐
	Anxiety/panic	☐	☐	☐				

20. Family History: Please check the "Yes" or "No" box if any relatives have/had any of the following illnesses.
If yes, please indicate which relative(s) have/had the problem.

	Yes	No	
Back problems	☐	☐	______________________________
Rheumatoid Arthritis	☐	☐	______________________________
Heart problems/murmurs	☐	☐	______________________________
Diabetes	☐	☐	______________________________
Cancer	☐	☐	______________________________
Bleeding Disorder	☐	☐	______________________________
Anesthesia problems	☐	☐	______________________________

Reviewed By (Initials) _________

Initial History(cont'd) **Name:** ____ **Date** ____/____/_____

21. **Are you currently:** ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated
22. **Where do you live?** ❑-Apartment ❑2-Story House ❑-Ranch-Style House
23. **How many children do you have?** _________ Ages ______________________ How many live with you ____________
24. **Do you smoke cigarettes?** ❑ Yes ❑ No Packs per day: __________
25. **Do you drink alcoholic beverages?** Yes ❑ No ❑ How much each day?__________
26. **Do you take or have you ever used any street drugs(ex-marijuana, cocaine, etc.)?** Yes ❑ No ❑
27. **Are you working?** ❑ Yes ❑ No ❑ Full-Time ❑ Part-Time
    When did you last work? Date: _______________ **Is there light duty available at work?** ❑ Yes ❑ No
28. **Occupation and job duties:** (ex: sitting at a computer, lifting, bending, twisting, etc.)
    ____
29. **If you are not working now, do you see yourself….** (check all that apply)
    - ❑ returning to the same job
    - ❑ modifying your work
    - ❑ changing jobs – same employer
    - ❑ changing jobs – different employer
    - ❑ retraining or returning to school
    - ❑ applying for early retirement or long-term disability benefits
30. **Do you enjoy your work?** ❑ Yes ❑ No
31. **Do you like your co-workers?** ❑ Yes ❑ No
32. **What hobbies or activities (work, sports, and hobbies) do you hope to return?** ______________________________________
    ____

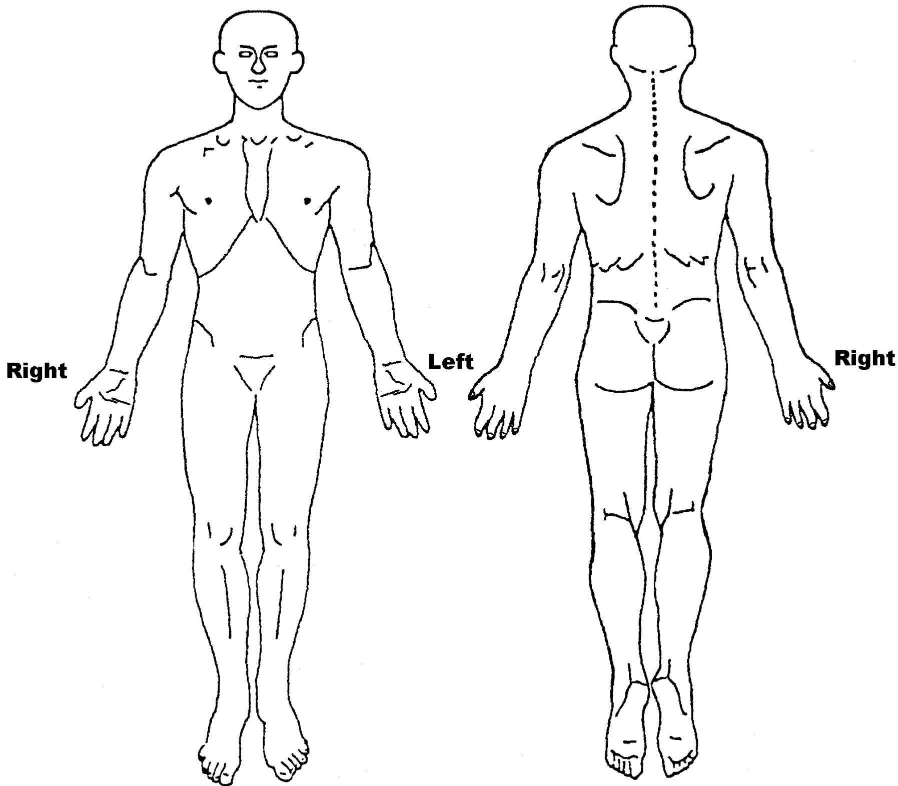
PAIN DRAWING

INSTRUCTIONS:

Mark these drawings according to where you hurt (if the back of your neck hurts, mark the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate which sensations you feel by placing the marks shown below.

KEY

XXX for Burning	/// for Stabbing	+++ Aching	**OOO** Pins & Needles	=== Numbness



PAIN LEVEL: (Circle one)

0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
(no pain)	**(tolerate pain without medication)**			**(requires medication)**				**(go to ER)**	**(severe pain) (admit to hospital for pain control)**	

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Reviewed by (initials) _______

See attached dictation ❑