

SOUTHWEST SPORT & SPINE CENTER, INC. MEDICAL HISTORY

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you.

Name: _____

Date of Birth: _____

Occupation/Leisure Activities: _____

Allergies: Are you latex sensitive? Yes No

List any medication(s) you are allergic to: _____

List any allergies we should know about: _____

Which of the following OVER THE COUNTER MEDICATIONS have you taken in the last week?

- YES NO Advil/Motrin/Ibuprofen
 YES NO Antacid
 YES NO Antihistamines
 YES NO Aspirin
 YES NO Decongestants
 YES NO Laxatives
 YES NO Tylenol
 YES NO Vitamins/Minerals/Supplements
 Other: _____

Therapist Use Only

List any PRESCRIPTION meds you are currently taking (including pills, injections, and/or skin patches)

- 1 _____ Purpose: _____
 2 _____ Purpose: _____
 3 _____ Purpose: _____

Have you **EVER** been diagnosed as having any of the following conditions?

- | | |
|--|--------------------------------------|
| YES NO Anemia | YES NO Arthritis Conditions |
| YES NO Asthma | YES NO Joint Replacement |
| YES NO Cancer | YES NO Multiple Sclerosis |
| YES NO Chemical Dependency (i.e. alcoholism) | YES NO Nervous System Disorder |
| YES NO Depression | YES NO Osteoporosis |
| YES NO Emphysema/bronchitis | YES NO Circulation Problems |
| YES NO Stroke | YES NO Diabetes |
| YES NO Thyroid Problems | YES NO Epilepsy / Seizures |
| YES NO Tuberculosis | YES NO Heart Disease (or Pacemaker) |
| YES NO Other: _____ | YES NO Hepatitis |
| _____ | YES NO High Blood Pressure |
| _____ | YES NO Kidney Problems |
| _____ | YES NO Urinary or Fecal Incontinence |

Have you recently noted:

- | | |
|---------------------------------|-----------------------------|
| YES NO Weight Loss/Gain | YES NO Weakness |
| YES NO Nausea/Vomiting/Diarrhea | YES NO Fever/Chills/Sweats |
| YES NO Sleep Loss | YES NO Numbness or Tingling |
| YES NO Fatigue | YES NO Lack of Coordination |
| | YES NO Difficulty Walking |

FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No

Therapist Use Only: _____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury: _____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Have you declared the Advanced Clinical Directive of DO NOT RESUSCITATE? Yes No
How many days per week do you drink alcohol?
How much caffeinated coffee or caffeine containing beverages do you drink per day?
Are you currently receiving home health care?: Y N

Are you currently under the care of:

YES	NO	Medical Doctor	YES	NO	Psychiatrist	YES	NO	Physical Therapist
YES	NO	Osteopath	YES	NO	Psychologist	YES	NO	Other (please list):
YES	NO	Dentist	YES	NO	Chiropractor	_____		

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.):

During the past month have you been feeling down, depressed or hopeless? Yes No
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? Yes No
During the past month have you been bothered by having little interest in doing things? Yes No

Concerning the condition for which you were referred for therapy, have you had a recent:

MRI: Y N X-Ray Y N Cat Scan Y N Where?

Have you had Therapy in the past 12 months? Y N Where:

How many packs of cigarettes do you smoke a day?

Has anyone in your immediate family (parents, brother, sister) ever been treated for any of the following?

YES	NO	Anemia	YES	NO	Headaches/migraines
YES	NO	Arthritis	YES	NO	Heart Disease
YES	NO	Cancer	YES	NO	High Blood Pressure
YES	NO	Chemical Dependency (i.e. alcoholism)	YES	NO	Kidney Disease
YES	NO	Diabetes	YES	NO	Mental Illness
YES	NO	Epilepsy	YES	NO	Stroke

Therapist Use Only: