APM&R
BRAIN • PAIN • SPORTS • SPINE

Name: _____ **DOB:** ___ / ___ / ___ **Today's Date:** ___ / ___ / ___

PATIENT HISTORY FORM – INITIAL VISIT PG 1/3

Referral Information:

(Who Referred You)

Name: _____

Address: _____

City, State, Zip: _____

(Primary Doctor/Internist)

Name: _____

Address: _____

City, State, Zip: _____

Current Employment:

Name: _____ Occupation: _____

Address: _____ City, State, Zip: _____

Presenting Problem:

(Check all that apply)

- ☐ Pain
- ☐ Sensory Loss
- ☐ Weakness
- ☐ Limited Motion
- ☐ Cognitive Problems
- ☐ Memory Loss
- ☐ Speech Disorder
- ☐ Swallowing Disorder
- ☐ Balance Problems
- ☐ Clumsiness / Falls
- ☐ Walking Difficulty
- ☐ Bladder Difficulty
- ☐ Problem Climbing Steps
- ☐ Impaired Hand Coordination
- ☐ Spasms / Spasticity
- ☐ Skin Breakdown
- ☐ Impairment in Ability to Work
- ☐ Inability to Care for Self
- ☐ Difficulty With Communication
- ☐ Change in Medical Condition

Description of why you are seeing the doctor *(use back of pg 3 for additional space)*: _____

_____

_____

_____

_____

_____

_____

Severity of Pain, if applicable: *(Circle the area on the line which best describes your current level of pain)*

No Pain — Moderate Pain — Worst Possible Pain

What makes your pain worse?

- ☐ Lying Down
- ☐ Sitting Down
- ☐ Standing
- ☐ Walking
- ☐ During Exercise
- ☐ After Exercise
- ☐ Bending
- ☐ Lifting
- ☐ Coughing
- ☐ Sneezing
- ☐ Bowel Movement
- ☐ Reaching
- ☐ Twisting
- ☐ Pull/Push
- ☐ Work Activities
- ☐ Riding in Car
- ☐ Other_____

What makes your pain better?

- ☐ Lying Down
- ☐ Sitting Down
- ☐ Standing
- ☐ Walking
- ☐ Manipulation
- ☐ Massage
- ☐ Prescription Pain Pill
- ☐ Muscle Relaxing
- ☐ Coughing
- ☐ Sneezing
- ☐ Bowel Movement
- ☐ Reaching
- ☐ Twisting
- ☐ Pull/Push
- ☐ Work Activities
- ☐ Riding in Car
- ☐ Other_____

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Name: _____ **DOB:** ___ / ___ / ___ **Today's Date:** ___ / ___ / ___

PATIENT HISTORY FORM – INITIAL VISIT PG 2/3

Past Medical History:

_____
_____
_____
_____

Past Surgical History:

_____
_____
_____
_____
_____
_____

Medications: *(Rx and Non-Rx)*

_____
_____
_____
_____
_____

Medication Allergies:

_____
_____
_____
_____

Check any that apply:

- ☐ Injury on the Job *(date)* _____
- ☐ Auto Accident *(date)* _____
- ☐ Working with Rehab Nurse
- ☐ Receiving Workers Comp.
- ☐ Receiving Disability Income
- ☐ Legal Proceedings Pending *(Attny Name:_____)*

Do You: *(If Yes, indicate what you use and the amount per day)*

- ☐ Smoke? _____
- ☐ Use Alcohol? _____
- ☐ Use Non-Rx Drugs? _____

_____

Currently Working?

- ☐ No, last day worked: _____
- ☐ Yes, without restrictions
- ☐ Yes, restrictions: _____

Family History:

A= Alive
D= Deceased / Age
Example

Mother	/ 1				
Father	/ 2				
Brothers	/ 3	/ 4	/ 5	/ 6	
Sisters	/ 7	/ 8	/ 9	/ 10	

Family Medical History: *(If applies, indicate which member using numbers above – modify as necessary)*

___ Heart Disease	___ Hypertension
___ Cancer	___ Alzheimers
___ Stroke	___ Arthritis
___ Diabetes	___ Osteoporosis

Review of Systems *(circle all that apply, then expand on below)*

Constitutional

Fevers	Y N
Chills	Y N
Weight Loss	Y N
Night Sweats	Y N
Travel Out of Country	Y N
Skin Rashes or Lesions	Y N

Neurologic

Tremors	Y N
Dizziness	Y N
Seizures	Y N
Sensory Loss	Y N
Weakness	Y N
Loss of Balance	Y N

Cardiovascular

Chest Pain	Y N
Rapid Heartbeat	Y N
High Blood Pressure	Y N
Fainting Spells	Y N
Irregular Hearbeat	Y N
Swelling in Ankles/Feet	Y N

Endocrine

Fatigue/Wt. Gain	Y N
Thermal Intolerance	Y N
Excessive Thirst	Y N
Goiter	Y N
Fluid Retention	Y N

Musculoskeletal

Joint Pain	Y N
Swollen Joint(s)	Y N
Neck or Back Pain	Y N
Weakness	Y N
Limited Movement	Y N

Special Senses

Blurred Vision	Y N
Double Vision	Y N
Loss of Vision	Y N
Loss of Taste/Smell	Y N
Loss of Hearing	Y N

Gastrointestinal

Abdominal Pain	Y N
Heartburn	Y N
Difficulty Swallowing	Y N
Blood in Stools	Y N
Black/Tarry Stools	Y N
Incontinence	Y N

Respiratory

Wheezing	Y N
Shortness of Breath	Y N
Chronic Cough	Y N
Coughing Blood	Y N
Frequent URI	Y N

OB/Gynec

Date of LMP	_____
Date of Last Pap	_____
Last Mammogram	_____
# of Pregnancies	_____
# of Living Children	_____
Excessive Bleeding	Y N
Breast Mass/Discharge	Y N

Genitourinary

Urinary Retention	Y N
Urinary Frequency	Y N
Decreased Stream	Y N
Blood in Urine	Y N
Incontinence	Y N
Testicular Pain/Mass	Y N
Erectile Dysfunction	Y N

Ears/Nose/Throat

Ear Pain	Y N
Ringing in Ears	Y N
Sore Throat	Y N
Sores in Mouth	Y N
Sinus Congestion	Y N
Sinus Drainage	Y N

Hemat./Lymphatic

Swollen Glands	Y N
Tender Glands	Y N
Blood Transfusion	Y N
Excessive Bruising	Y N
Spontaneous Bleeding	Y N
Edema	Y N

Psychiatric

Depression	Y N
Anxiety	Y N
Flight of Ideas	Y N
Thoughts of Suicide	Y N
Interrupted Sleep	Y N

The information obtained through this section of these forms provides vital information that allows our doctors to consider all the information about your condition to facilitate optimal care. Please take your time and fill these in as completely as possible. Circle any item if you need clarification about it at the time of your visit.

_____
_____
_____

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Name: _____ **DOB:** ___ / ___ / ___ **Today's Date:** ___ / ___ / ___

PATIENT HISTORY FORM – INITIAL VISIT PG 3/3

Pain Diagram:
Mark these drawings according to where you feel your symptoms are located. Please use the following Diagram Key to indicate what you are feeling or have felt. If the markings don't apply to what you feel, then try to use your own words to describe what it is that you feel.

Diagram Key

Numbness
= = = = =

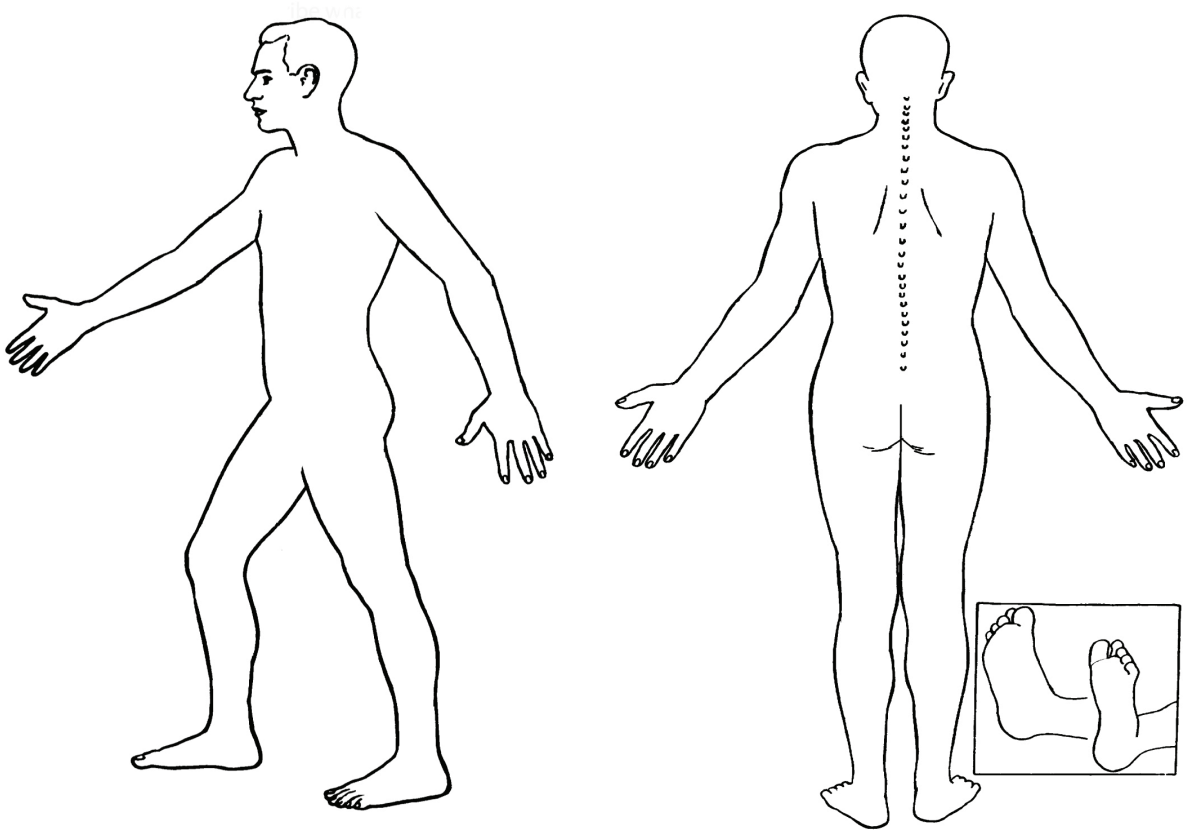
Pins and Needles
0 0 0 0 0

Burning
X X X X X

Stabbing
/ / / / /

Aching
* * * * * *

Throbbing
+ + + + + +



Previous Tests: *(Check any that apply)*

✔		Date	Where Done
☐	Plain X-rays		
☐	CT Scan		
☐	MRI		
☐	Myelogram		
☐	Discogram		
☐	EMG/NCS		

Describe Results: _____

_____

_____

_____

_____

Previous Treatments: *(Check any that apply)*

✔		Date	Where Done
☐	Physical Therapy		
☐	Chiropractic		
☐	Acupuncture		
☐	Bracing/Orthotic		
☐	Pain Clinic/Epidural		
☐	Surgery		
☐	Rest		
☐	Medications		

Describe Results: _____

_____

_____