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Welcome! We appreciate your help in providing this information we need to complete your medical record.

Name: _____
Last First MI
Home Street Address _____
City State Zip
Phone: _____
Home Work
Cell E-mail
Date of Birth: _____ Age: _____
Social Security #: _____
Required
Driver's License #: _____

Employer Name: _____
Occupation: _____
 Full time Part time Unemployed Medical Leave
Physician's Name: _____
Phone number: _____ City: _____
Date of next scheduled appointment: _____
In case of emergency, please notify:
Name: _____ Ph: _____
Have you ever seen one of our therapists before? Yes No
How did you hear about us? _____
Please be specific

(Please provide insurance card and driver's license to be copied.)

Primary Insurance: _____ Secondary Insurance: _____
Insured's Social Security#: _____ Insured's Date of Birth: _____
Does your employer consider this a work injury? Yes No
Is this injury part of an open car accident case or other personal injury lawsuit? Yes No

I have read and fully understand Exclusively Spine Physical Therapy, LLC's Notice of Privacy Practices. I understand that Exclusively Spine Physical Therapy, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice in writing. I also understand that Exclusively Spine Physical Therapy, LLC will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge the use and disclosure of my personal health information for purposes as noted in Exclusively Spine Physical Therapy, LLC's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I have read and fully understand Exclusively Spine Physical Therapy's attendance policy.

Please provide your e-mail address if you would like to receive our one page monthly newsletter about neck and back related health or notification of future announcements or specials. Note: Exclusively Spine Physical Therapy will not sell or distribute this address to any other vendors or companies.

Email address: _____

I attest that the above information is true and correct.

Printed Name: _____

Signature: _____

Date: _____

Patient Name: _____ Date: _____

CURRENT SYMPTOMS: *Please describe the symptoms you are seeking treatment for:*

Please use the key below to mark where your symptoms are located and what kind of symptoms you are having.

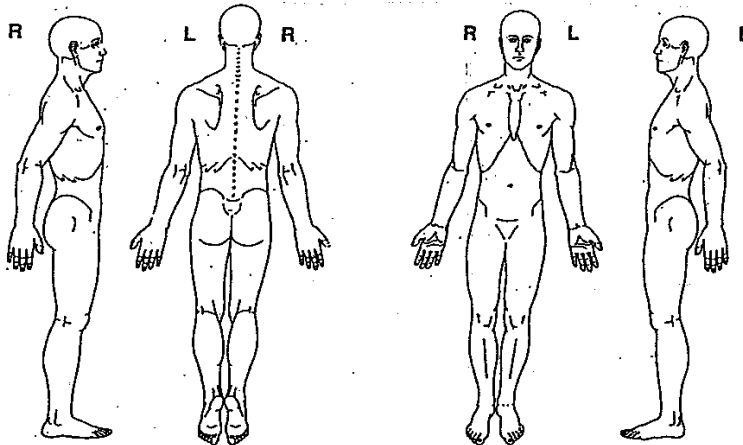
KEY:

Numbness -----

Pins & Needles oooo

Burning Pain xxxxx

Stabbing Pain /////



PAIN LEVELS/SYMPTOM HISTORY

- Please **circle** the number that describes your pain at **worst**. ○
- Please put a **box** around the number that describes your pain at **best**. □
- Please **underline** your **current pain level**. _____

Body part _____	best	0	1	2	3	4	5	6	7	8	9	10	worst
Body part _____	best	0	1	2	3	4	5	6	7	8	9	10	worst
Body part _____	best	0	1	2	3	4	5	6	7	8	9	10	worst
Body part _____	best	0	1	2	3	4	5	6	7	8	9	10	worst

Are you currently seeing a physician for these symptoms: Yes No

Physician Name: _____ Next scheduled appointment: _____

How long have you had these symptoms? _____

Was the onset of your symptoms gradual or sudden? Gradual Sudden

Have you had similar symptoms in the past? Yes No **More than one episode?** Yes No

Since onset are your symptoms getting: Better Worse Not changing

Please check all that apply about your current symptoms:

- | | | |
|---|--|--|
| <input type="checkbox"/> Work-related injury | <input type="checkbox"/> Recurrence of previous injury | <input type="checkbox"/> Injury related to falling |
| <input type="checkbox"/> Motor vehicle accident | <input type="checkbox"/> Injury related to lifting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cause unknown | <input type="checkbox"/> Athletic/recreational injury | |

As the day progresses, do your symptoms: Increase Decrease Stay the same

What position do you sleep? Back Stomach Right side Left side Chair/Recliner Other: _____

Does the pain wake you at night? Yes No **If yes, is it present:** While lying still With position change

Patient Name: _____ Date: _____

Do you have pain/stiffness upon getting out of bed in the morning? Yes No

What *aggravates* your symptoms? (check all that apply)

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Lying down | <input type="checkbox"/> Looking up overhead | <input type="checkbox"/> Reaching overhead |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Going from sit to stand | <input type="checkbox"/> Talking, chewing | <input type="checkbox"/> Reaching behind back |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Up/down stairs | <input type="checkbox"/> Swallowing | <input type="checkbox"/> Reaching in front of body |
| <input type="checkbox"/> Squatting | <input type="checkbox"/> Stress | <input type="checkbox"/> Coughing/sneezing | <input type="checkbox"/> Reaching across body |
| <input type="checkbox"/> Sleeping | | <input type="checkbox"/> Taking a deep breath | |
| <input type="checkbox"/> Bending | | | |
| <input type="checkbox"/> Recreation/sports including _____ | | | |
| <input type="checkbox"/> Housework including _____ | | | |
| <input type="checkbox"/> Yard Work including _____ | | | |
| <input type="checkbox"/> Other _____ | | | |

What *relieves* your symptoms? (check all that apply)

- | | | |
|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Massage | <input type="checkbox"/> Nothing |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Topical Creams | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Stretching | _____ |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Exercise | _____ |
| <input type="checkbox"/> Heat | <input type="checkbox"/> Wearing a splint/orthosis | _____ |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Medication | _____ |

PREVIOUS TREATMENTS: Describe any previous treatments you have had for these symptoms:

Treatment: _____	Date: _____	Response to Treatment: _____

PREVIOUS TESTING: Have you had any imaging/testing performed for this condition?

	Yes	No	Approximately when and where were these images taken?
X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dexascan	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

PAST MEDICAL HISTORY	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis/Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Panic Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Aortic Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Ankylosing Spondylitis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Spondylolisthesis	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Injury	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Conditions	<input type="checkbox"/>	<input type="checkbox"/>

Patient Name: _____ Date: _____

Kidney or Bladder Disorder
Bleeding Disorder
Current Fever/Chills
Numbness genital/anal area
Alcohol use
If yes how much? _____ How often? _____
Smoke
If yes how many packs per day? _____

Visual Impairment
Hearing Impairments
Unexplained weight change
Bowel/bladder problems
Drug Use
If yes what, how often? _____
Current Pregnancy
If yes how many months? _____

If yes to any of the listed conditions please briefly explain the condition and date of diagnosis:

Is there any other information regarding your past medical history not listed we should know about? Yes No

Please list any medications prescription and non prescription, vitamins, home remedies, birth control pills, herbs you are taking. Please list dosage and frequency:

Medication: _____ **Dosage (e.g. mg/pill):** _____ **Frequency:** _____ **What are you taking medication for:** _____

Are you allergic to any medications? Yes No *If yes, please list:* _____

Please list all surgeries you have had: **Surgery:** _____ **Date:** _____

FAMILY MEDICAL HISTORY

Has anyone in your immediate family ever had any of the following:

	Yes	No	Relation		Yes	No	Relation
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer/Type	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	_____	Elevated Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____	COPD	<input type="checkbox"/>	<input type="checkbox"/>	_____
Death before 50	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please list any other family history that may be important to your care: _____

HOME ENVIRONMENT

Married Single Living Alone Children Ages: _____

Is help available from spouse/children/roommate with household activities and yard work activities ? Yes No

Does your home have stairs that you are required to climb? _____

Other relevant information about home environment: _____

WORK ENVIRONMENT

- Employed Student Retired Unemployed Homemaker
- Full time Part Time Limited Hours _____ Restricted Duty _____
- Employed but presently not working due to my condition
- Previously employed and receiving disability benefits for my condition

Are you currently seeking disability benefits for this condition? Yes No Short Term Long Term

What is/was your occupation? : _____

What are your physical activities at work? (check all that apply)

- Sitting Standing Phone Use Computer Use Heavy Lifting Repetitive lifting
- Heavy equipment operation Driving Other: _____

PREVIOUS FUNCTIONAL ACTIVITY LEVEL

Prior to this injury....

- How would you rate your overall health? Excellent Good Average Fair Poor
 - Were you able to perform all self care activities? Yes No
 - Were you able to perform all housework/child care /yard work activities? Yes No
 - Were you able to perform all work duties? Yes No
 - Did you exercise outside of your normal everyday activities? Yes No
- If yes, how often and what type: _____
- What did your recreational/sport activities consist of: _____

CURRENT FUNCTIONAL ACTIVITY LEVEL

Since the current injury....

If you answer no please elaborate on line below

- Are you able to perform all self care activities? Yes No
- _____
- Are you able to perform all housework/child care /yard work activities? Yes No
- _____
- Are you able to perform all work duties? Yes No
- _____
- Are you able to tolerate your previous exercise activities ? Yes No
- _____
- Are you able to tolerate your previous recreational/sport activities? Yes No
- _____
- Are there any other activities that you are unable to do? Yes No
- _____
- _____

What are your goals for your treatment? _____

Other information you believe is relevant to your treatment: _____

