balance
REHABILITATION AND
HEALTH SCIENCE, LLC

Patient Information Record

Neck and Back

Name: _____

MD:_____

Date: _____

Age: _____ Height_____Weight:_____

HISTORY OF INJURY:

1. What is your primary complaint? _____Left or Right?_____
2. How and when (date) did the present symptom(s) begin?_____
3. A. Precisely where did the pain start? (please indicate on diagram) **X = numbness** **P = where pain started**
   B. Where did the pain spread? (please indicate on diagram) **T = tingling** **R = where pain spread**
4. On a scale of 0-10 (10 being excruciating) how painful was it:
   A. When it started? (please circle) 0 1 2 3 4 5 6 7 8 9 10
   B. At it's best? (please circle) 0 1 2 3 4 5 6 7 8 9 10
   C. At it's worst? (please circle) 0 1 2 3 4 5 6 7 8 9 10
   D. How is it today? (please circle) 0 1 2 3 4 5 6 7 8 9 10
5. Did you undergo surgery? Yes___ No___ If yes, what was the date of surgery? ___/___/_____
6. Does it throb ____twinge____burn _____give you numbness/tingling _____?
7. What activities make your pain worse? _____
8. What if anything eases your pain? _____
9. Can you get comfortable at night? ___Yes ___ No
10. How does your back feel on rising in the morning? stiff____ sore____ fine____
11. Once you start moving about, does it:

worsen _____ ease _____stay the same _____

12. What is it like at the end of the day compared to the beginning?
better _____ worse _____ same_____
13. What is the effect of coughing?

better ____ worse ____ same_____

14. Do you have any problems with your bowels or bladder? _____
15. Have you ever had anything similar before?____

A. Is it increasing frequency? _____

B. Increasing severity? _____

C. Changing in character? _____

D. If yes, please describe_____

E. Can you identify what causes it? If so what? _____

_____

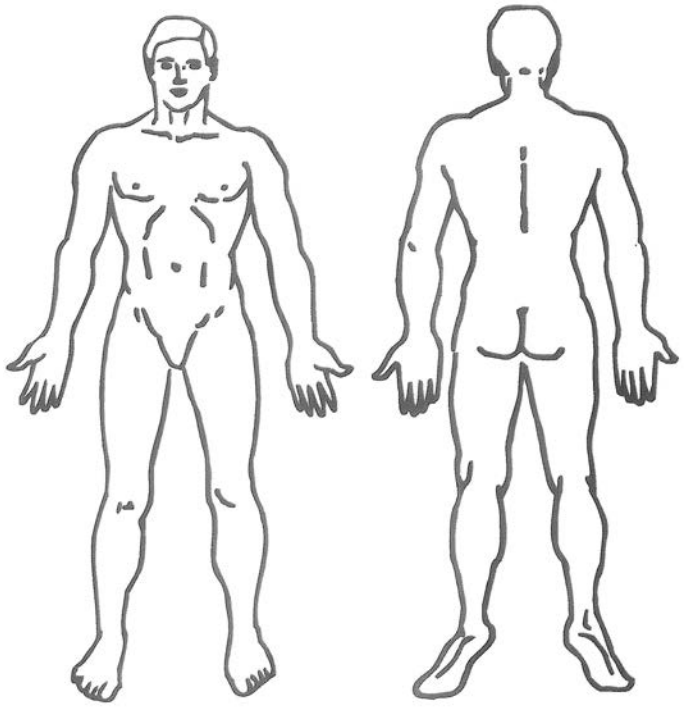
F. What did you do to resolve it?_____

16. Have you been hospitalized for this? _____

If so where? _____

17. Have you undergone a diagnostic medical test for this? _____

If so where? _____



R **L** **L** **R**

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1. MEDICAL HISTORY (circle one) DO YOU HAVE OR HAVE HAD:

Yes	No	High blood pressure?	Yes	No	Impaired vision?
Yes	No	Heart disease or other cardiac condition?	Yes	No	impaired hearing?
Yes	No	Angina (chest pain)?	Yes	No	Hepatitis?
Yes	No	Shortness of breath?	Yes	No	Asthma / or Allergies?
Yes	No	Lung disease?	Yes	No	Osteoporosis?
Yes	No	Stroke?	Yes	No	Bleeding Disorders?
Yes	No	Recent weight loss/gain?	Yes	No	Sleep Disturbances?
Yes	No	Unusual joint pain and/or swelling?	Yes	No	Diabetes?
Yes	No	Dizziness and/or a History of falls?	Yes	No	Depression?
Yes	No	A history of fractures?	Yes	No	HIV/AIDS?
Yes	No	A history of cancer?	Yes	No	Arthritis?
Yes	No	Increase in frequency or intensity of headaches?	Yes	No	Seizures?
Yes	No	Are you now, or do you have any reason to believe you may be pregnant?			

2. Please rate on a scale of 0-10 how painful the following activities are; use space provided for additional comments.

Rolling over in bed _____ Ascending/descending stairs _____

Transfer to/from bed _____ Transfer to/from car _____

Bathing _____ Driving _____

Dressing _____ Walking _____

Grooming _____ Sitting _____

Carrying _____ Standing _____

Household Cleaning _____ Bending _____

Reaching level/overhead _____ Lifting _____

Meal preparation _____ Child Care _____

Using the phone _____ Other _____

3. Please list ALL medications, dosage and purpose.

_____

_____

4. Please list all surgeries and approximate dates. _____

_____

5. Please indicate diagnostic tests for this problem. _____

_____

6. Have you seen anyone else for your current problems? If so, please list. _____

_____

Consent to Medical Treatment

I, _____, voluntarily consent to diagnostic procedures and related medical treatment as recommended by my physical therapist and their designees, and acknowledge that no guarantees have been or can be made as to the result of such treatments. This questionnaire is considered a part of your confidential medical record.

Signature_____ Date_____

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