balance
REHABILITATION AND
HEALTH SCIENCE, LLC

Patient Information Record
Neck and Back

Name:_____

MD:_____

Date: _____

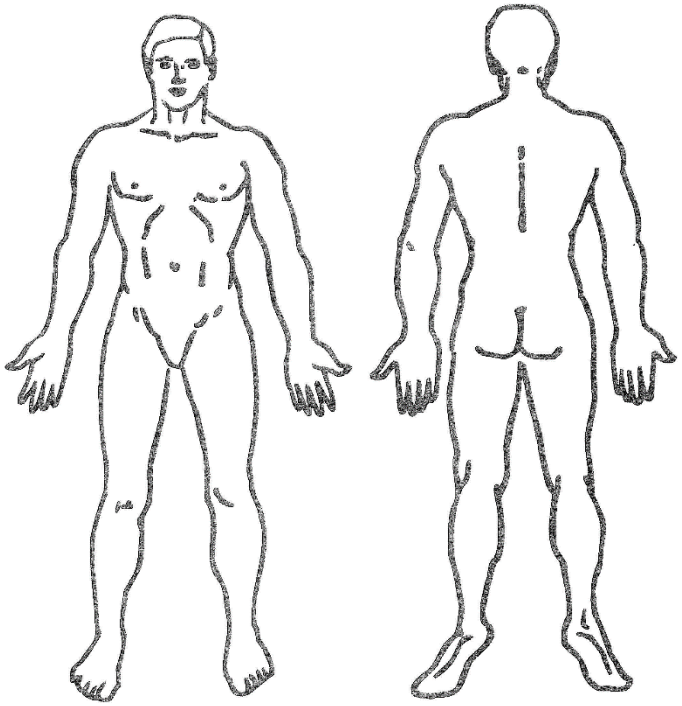
Age: _____ Height_____Weight:_____

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?
   B. At it's best?
   C. At it's worst?
   D. How is it today?
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? _____



Christopher Pierce MSPT, CSCS | cpierce@balance-rehab.com
Peter Olson, MPT, OMT, ATC | polson@balance-rehab.com

Stephen Ellis, PT
sellis@balance-rehab.com
Nancy Manchester, MPT
nmanchester@balance-rehab.com
Catherine Schilling, PT
cschilling@balance-rehab.com
Kathryn Cortelyou, PT, SCS
kcortelyou@balance-rehab.com
Michelle Fecteau, PT
mfecteau@balance-rehab.com

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

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

Christopher Pierce MSPT, CSCS | cpierce@balance-rehab.com Peter Olson, MPT, OMT, ATC | polson@balance-rehab.com

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Nancy Manchester, MPT nmanchester@balance-rehab.com
Catherine Schilling, PT cschilling@balance-rehab.com
Kathryn Cortelyou, PT, SCS kcortelyou@balance-rehab.com
Michelle Fecteau, PT mfecteau@balance-rehab.com