■ PHYSICIANS ■
BACK AND NECK CLINIC

■ CHRISTOPHER E. DOERR, D.O.

Medical History Form

Referred by:_____

Patient's Name _____ Date _____

DOB _____ Age_____ Right / Left handed Male / Female Height _____ Weight _____

CHIEF COMPLAINT/PRESENT ILLNESS

What is the main problem for which you are here? _____

Date this problem first began _____

Is this the first time you've had this problem? _____ If no, describe how long and how often this problem has occurred and how it first started. _____

_____

❑ Work Related ❑ Motor Vehicle ❑ Other _____

Describe injury _____

Give exact date and activity _____

Which physician(s) have you seen to help you with this problem?_____

What was your diagnosis?_____

What did s/he recommend?_____

Did you complete the recommended plan of care? _____ If no, what prevented you from doing so?_____

_____

Did you have any of the following to help with this problem?

❑ Physical Therapy When _____ Where _____ Did it help? _____

❑Chiropractic Care When _____ Where _____ Did it help? _____

❑ Massage Therapy When _____ Where _____ Did it help? _____

❑ Injections When _____ Where _____ Did it help? _____

❑ Surgery When _____ Where _____ Did it help? _____

Do you have a prior history of back or neck problems? _____ If yes, what kind of problem and when did it begin?_____

Physician Notes _____

_____

_____

_____

_____

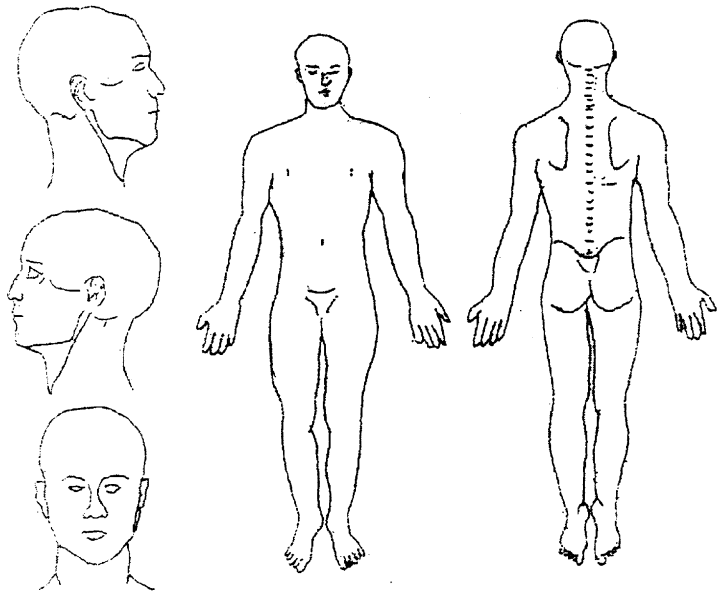
_____

1. How often do you have pain?
   ❒ rarely ❒ some of the time ❒ most of the time ❒ all of the time

2. Do you have weakness? ❒ Yes ❒ No Explain:_____

3. Are your bowels and bladder working fine? ❒ Yes ❒ No Explain:_____

4. Please circle the areas of your body where you feel pain:



Do you have symptoms radiating to:

Shoulder	❒ Left	❒ Right
Shoulder blade	❒ Left	❒ Right
Arm	❒ Left	❒ Right
Forearm	❒ Left	❒ Right
Hand	❒ Left	❒ Right
Buttocks	❒ Left	❒ Right
Thighs	❒ Left	❒ Right
Legs	❒ Left	❒ Right
Feet	❒ Left	❒ Right

Describe the symptom:
Burn Stab Tingle Numb Other_____

5. Beside the circles you've drawn above, please indicate your **worst** intensity of pain with the number that corresponds to the scale below:

0	1	2	3	4	5	6	7	8	9	10
No Pain		Mild Pain		Moderate Pain		Severe Pain		Very Severe Pain		Worst Possible Pain

6. Use the numbered scale below to answer to what extent has your pain affected:
   ____ Mobility ____ Sleep ____ Work ____ Exercise ____ Concentration ____ Appetite
   ____ Social Activities ____ Relationships with others ____ Emotions ____Other_____

0	1	2	3	4	5	6	7	8	9	10
Not at all		Rarely		Occasionally		Frequently				All the time

FUNCTIONAL INVENTORY

It is important for us to know what activities aggravate your pain and what helps to relieve it. Even if your pain is present all of the time, certain activities or positions would tend to make your pain somewhat better or worse. Please answer all circumstances. If a question does not apply, please check "N/A".

Sitting	Better	Worse	N/A	Physician Notes
On a hard straight chair	❑	❑	❑	
On a soft couch	❑	❑	❑	
On the floor with legs crossed	❑	❑	❑	
Arising				
From a chair	❑	❑	❑	
From bed	❑	❑	❑	
From the car	❑	❑	❑	
Standing				
In one place	❑	❑	❑	
Walking				
Normal pace	❑	❑	❑	
Briskly	❑	❑	❑	
Uneven surfaces	❑	❑	❑	
Long distances	❑	❑	❑	
Lying Down				
On belly	❑	❑	❑	
On back	❑	❑	❑	
- with legs straight	❑	❑	❑	
- with legs bent	❑	❑	❑	
On left side	❑	❑	❑	
On right side	❑	❑	❑	
Bending				
Forward/down	❑	❑	❑	
Returning upright	❑	❑	❑	
Arching backwards	❑	❑	❑	
Sidebending left or right	❑	❑	❑	
Slight bending (brushing teeth)	❑	❑	❑	
Changing positions/postures				
In general	❑	❑	❑	
Turning in bed	❑	❑	❑	
After sitting or lying for a long time	❑	❑	❑	
From standing to sitting	❑	❑	❑	
Maintaining positions/postures				
In general	❑	❑	❑	
At desk/computer	❑	❑	❑	
In bed	❑	❑	❑	

FUNCTIONAL INVENTORY (CONT'D)

Exercise/yardwork/sports	Better	Worse	N/A	Physician Notes
Beginning	❑	❑	❑	
During activity	❑	❑	❑	
Later/next day	❑	❑	❑	
Sudden movements				
Cough	❑	❑	❑	
Sneeze	❑	❑	❑	
Bumpy car ride	❑	❑	❑	
"Stress"				
In general	❑	❑	❑	

How long can you stand? (15 minutes, 1 hour, etc.) _____

How far can you walk? (yards, miles, 15 minutes, etc.) _____

Do you consider yourself to be generally flexible or stiff? _____

How far can you bend over? (touch my toes, ankles, knees, etc) _____

NECK-RELATED QUESTIONS

	Affects neck	Affects arms/hands	N/A	Physician Notes
Raising hands over your head	❑	❑	❑	
Looking up	❑	❑	❑	
Looking down	❑	❑	❑	
Turning head from side to side	❑	❑	❑	
Leaning head side to side	❑	❑	❑	

RELATED MUSCULOSKELETAL PROBLEMS

Have you ever had significant injury or surgery of the following areas:

❑ Shoulder ❑ Arm ❑ Wrist ❑ Hand ❑ Hip ❑ Knee ❑ Ankle ❑ Foot

If you checked any, please explain _____

_____

Do you have an area of concern that might "flare-up" when beginning an exercise program? _____

_____

Physician Notes _____

_____

_____

_____

_____

ALLERGIES

Are you allergic to any medicines? ❑Yes ❑ No If yes, please list: _____

_____

Are you allergic to anything else? (pollen, latex, animals, etc.) ? ❑ Yes ❑ No If yes, please list:

_____

MEDICATIONS

List all medicine that you take for **pain**: For how long? How often do you take it? Who prescribed it?

1. _____
2. _____
3. _____
4. _____

Please list **other** medications that you take, including vitamins:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

PAST MEDICAL HISTORY

Do you have or have you ever had any of the following:

❑ Diabetes
❑ High Blood Pressure
❑ Heart Disease
❑ Heart Attack
❑ Kidney Problems
❑ Cancer
❑ Liver/Gallbladder Problems
❑ Anemia
❑ Chest Pain/angina
❑ Hypoglycemia (low blood sugar)
❑ Fibromyalgia
❑ Chronic Fatigue Syndrome
❑ Migraine Headache
❑ Thyroid Disease
❑ Stomach Ulcer
❑ Acid Reflux or Hiatal Hermia
❑ Irregular Heartbeat
❑Prostate Problems
❑ Rupture or Hernia
❑ Bleeding Disorder
❑ Asthma/Breathing Difficulties
❑ Blood Clots in Legs or Lungs
❑ Elevated Cholesterol
❑ Irritable Bowel Syndrome
❑ TMJ
❑ Carpal Tunnel Syndrome

Surgeries/Procedures

❑Appendectomy
❑Cholecystectomy (gallbladder)
❑ Hernia Repair
❑ C-section
❑ Back or Neck Surgery, (specify below)
❑ Cardiac Catheterization
❑ Exercise Stress Test (for heart)
❑ Hysterectomy
❑ Joint Replacement
❑ Other Surgery (specify below)

_____

_____

Physician Notes _____

_____

_____

REVIEW OF SYSTEMS

Do you have a history of:

- ❑ Bleeding tendencies
- ❑ Swollen lymph nodes
- ❑Sleeping problems
- ❑Urine leakage
- ❑Change in stool color
- ❑ Frequent urination at night
- ❑ Blood in urine
- ❑Shortness of breath at rest
- ❑ Shortness of breath with little exertion
- ❑ Shortness of breath while lying flat
- ❑ Swelling of the feet, ankles, and/or legs
- ❑ Leg pain with prolonged walking
- ❑ Metal implants
- ❑ Recent fractures_____
- ❑ Rash
- ❑ Excessively tired
- ❑ Bowel or bladder abnormalities
- ❑ Diarrhea
- ❑ Constipation
- ❑ Pelvic pain
- ❑Hyperventilating spells
- ❑ Wheezing
- ❑Frequent cough (once-a-day or more)
- ❑ Coughing up phlegm or mucus daily
- ❑Profuse sweating at night
- ❑Frequent vomiting
- ❑ Recent weight gain/loss +/-_____lbs
- ❑ Balance problems
- ❑Coordination problems
- ❑ Blurred vision
- ❑ Joint pain/swelling (other than your spine)
- ❑Muscle pain/spasm
- ❑ Numbness/tingling of a leg or arm
- ❑ Weakness of a leg or arm
- ❑ If you are female, is there <u>any</u> chance you are pregnant?
- ❑ Sensitivity to chemicals
- ❑ Ringing in your ears
- ❑ Frequent headache
- ❑ Dizziness
- ❑ Emotionally traumatic event
- ❑Anxiety attacks
- ❑ Females: painful menstrual periods

Is there any information, that is not already included in this form, that you feel is important for us to know regarding your health? _____

FAMILY HISTORY

Please tell us about your immediate family and their health problems:

Family Member	Living Yes / No	Current Age or Age at Death	Medical problems or cause of death
Father			
Mother			
Brother(s)			
Sister(s)			

Physician Notes_____

OCCUPATIONAL HISTORY

Are you employed? ❑Yes ❑ No Are you currently working? ❑ Yes ❑ No Have you missed work due to this problem? ❑Yes ❑ No If yes, when did you last work? _____

Current Occupation: _____ Who do you work for?_____

What physical requirements are required of your job? ❑ sitting ❑ standing ❑ bending ❑ twisting ❑ lifting _____lbs

Please list occupations you have had in the past 10 years: _____

_____

SOCIAL HISTORY

Are you married? ❑ Yes ❑No Name of spouse_____

Do you have children? ❑ Yes ❑ No Ages_____

Who are your Doctors? General: _____

Specialists:_____

Do you smoke? ❑ No ❑ Yes, I have smoked ___ packs per day for _____ years

❑ I quit ____ years ago. I smoked for _____ years.

Do you drink more than 3 alcoholic beverages per week? ❑ Yes ❑ No If no, did you in the past? _____

Do you have a substance abuse problem or dependency on prescription medicine? ❑ Yes ❑ No If no, did you in the past? ❑ Yes ❑ No If yes, please explain _____

Do you use illicit drugs including but not limited to marijuana? ❑ Yes ❑ No If no, did you in the past? ❑ Yes ❑ No If so, what substance(s) _____

Do you exercise regularly? ❑ No ❑ Yes ___ of times per week Exercise activity _____

FINANCIAL RESPONSIBILITY

Who is responsible for paying your medical bills? _____

Primary Health Insurance _____ Secondary Health Insurance _____

Do you know how your insurance covers physical therapy? _____

Have you applied for disability? ❑ Yes ❑ No If yes, ❑ pending ❑ rejected ❑ favorable decision

For what type of disability are you applying? ❑ Short Term Disability ❑ Long Term Disability

❑ Social Security Disability

For what condition(s) have you claimed disability?_____

Do you have an attorney representing you for this condition? ❑ Yes ❑ No If yes, who_____