JUPITER MEDICAL CENTER

Patient History Information

Name: _____ Date: _____

Chief complaint/problem: _____

What do you hope to achieve through Therapy? _____

Any prior therapy related to this condition? _____

Medical History (circle all that apply):

Pacemaker	Memory loss	Kidney problems	Macular degeneration
High blood pressure	Fainting/dizzy spells	Bladder/reproductive infections	Wears glasses
Low blood pressure	Numbness/tingling	Incontinence	Reading
Heart disease	Headaches	Increased urinary urgency	Distances
Heart attack	Night sweats or fever	Increased urinary frequency	Other vision problems
Irregular heart beat	Recent weight loss/gain	Diabetes	Hearing problems
Chest pain	Changes in bowel/bladder	Thyroid Disease	Back injury
Congestive Heart Failure	Shortness of breath	Cancer	Neck injury
Heart murmur	COPD / Emphysema	Type: _____	Arthritis
Heart problems	Asthma	Liver disease	Joint injury/pain
Blood clot	Bronchitis	Drink alcohol	Broken bones
Stroke	Pneumonia	Stress/anxiety	Any metal implants
Paralysis	Tuberculosis	Depression	Any allergies:
Blood disease	Any lung problems	Currently pregnant	List: _____
Anemia	Smoker / Ex-smoker	Color blindness	_____
Bleed easily	Hernia	Cataracts	_____
Seizures / Epilepsy	Nausea / Vomiting (other than flu)	Glaucoma	_____

Any other Medical History not listed above: _____

_____

List previous major hospitalizations/surgeries? _____

_____

Have you had any recent tests performed regarding your condition? (circle all that apply)

X-Ray MRI CT Scan EMG Blood Tests Myelogram Bone Scan

Other: _____

Because of my condition, I have problems: (Circle all that apply)

Walking	Lifting	Reaching in cupboards	Doing recreational activities
Standing	Performing housework	Lying down	Swallowing
Getting in/out of bed	Dressing	Reading	Communicating
Going up/down curbs	Driving	Concentrating	Other: _____
Kneeling/squatting	Bathing/showering	Sitting	_____
Pushing/pulling	Picking up objects from ground	Working at my job	_____
Changing positions in bed	Carrying	Sleeping	_____

Are you experiencing any pain? YES NO (if yes, please complete the Pain Questionnaire, page 2)

Pain Questionnaire

Name: _____ Date: _____

How long have you had this pain? _____

Have you had pain of this type in the past? ❑ No ❑ Yes

What time of day is your pain **worst**? (circle one)

Morning Afternoon Evening Night Time

How **often** do you get your pain? (circle one)

Occasionally Frequently Constantly

What **helps** relieve your pain? _____

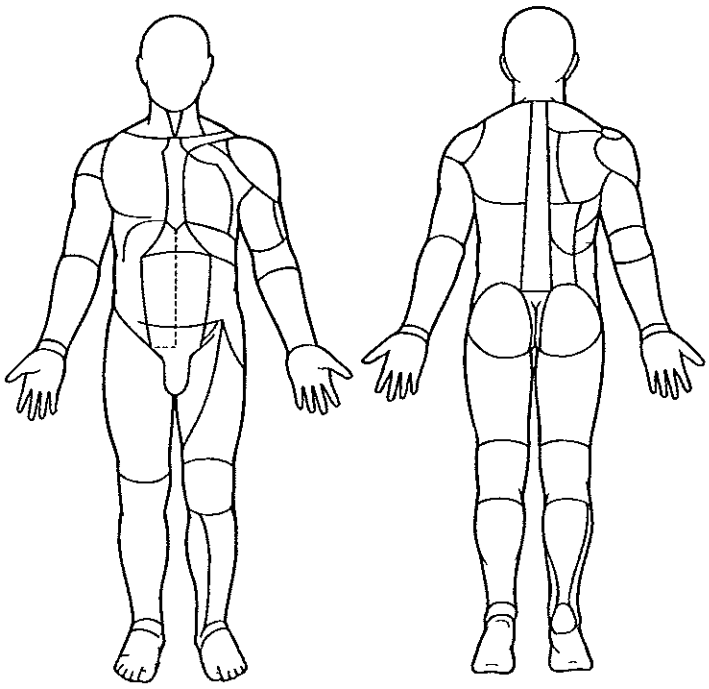
_____

What does **not** help? _____

_____

INDICATE ON DIAGRAM THE AREAS OF INCREASED PAIN

FRONT **BACK**



Circle the words that **best** describe your pain:

Tiring	Aching	Throbbing	Sharp
Tender	Numb	Burning	Stabbing
Dull	Nagging	Shooting	Unbearable

Please rate your pain by circling the appropriate number:

At **present**:	(no pain)	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	(Pain as bad as you can imagine)
At its **worst** over the past month	(no pain)	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	(Pain as bad as you can imagine)
At its **best** over the past month:	(no pain)	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	(Pain as bad as you can imagine)

My pain is *(check appropriate answer):*

Lying Down	❑ Better	❑ Worse	❑ No Effect
Sitting	❑ Better	❑ Worse	❑ No Effect
Standing	❑ Better	❑ Worse	❑ No Effect
Walking	❑ Better	❑ Worse	❑ No Effect
Coughing or sneezing	❑ Better	❑ Worse	❑ No Effect
When taking medication	❑ Better	❑ Worse	❑ No Effect