



INTEGRATED

Sport, Spine & Rehab

Confidential Patient Health Record

Today's Date: ___/___/___

Demographic Information

First: _____ MI: _____ Last: _____ Suffix: _____

Birth Date: ___/___/___ Sex: Male / Female / Other Marital Status: Single / Married / Other

Address: _____ Apt #: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

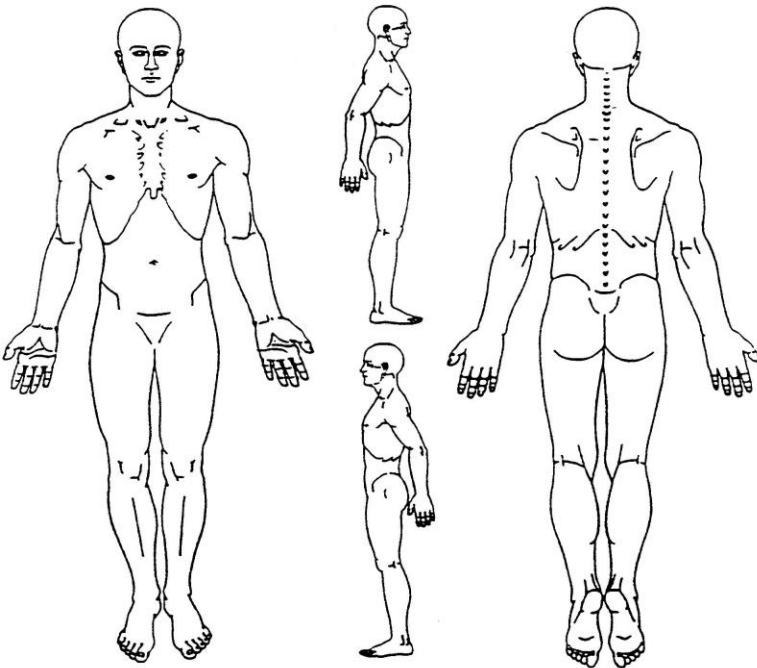
Email Address: _____ Preferred Contact Method: _____

Primary Care Provider: _____

Referral: Family _____ Friend _____ Dr. _____

Internet Insurance Plan Other: _____

Problem Areas



Circle on the body diagram and add the letter which corresponds to the symptom described.

Comments can be added to describe in fuller detail.

Key:

- N – Numbness B – Burning S – Stabbing
- T – Tingling A – Aching P – Pain

Comments:

Allergies: _____

Medications (with dosages): _____

Surgeries (with dates): _____

Previous injuries and dates treated: _____

******* Please fill out each area ONLY for the specific area you're wanting treated*******

Chief Complaint #1: _____

Onset/Approximate Onset Date: ____ / ____ / ____ What percent of the day do you feel symptoms? ____%

Pain Level (0 = no pain, 10 = worst imaginable pain): 0 1 2 3 4 5 6 7 8 9 10

How did the condition occur? _____

Quality (check all that apply):

- | | | | | | |
|-----------------------------------|-----------------------------------|------------------------------------|-----------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Burning | <input type="checkbox"/> Deep | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Cramping | <input type="checkbox"/> Numbness | <input type="checkbox"/> Radiating | <input type="checkbox"/> Stiffness |

Aggravating Factors (check all that apply):

- | | | | | | |
|-------------------------------------|---------------------------------------|---------------------------------------|------------------------------------|--|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Bending | <input type="checkbox"/> Stooping | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Coughing | <input type="checkbox"/> Straining | <input type="checkbox"/> Reaching | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Looking up | <input type="checkbox"/> Looking down | <input type="checkbox"/> Movement | <input type="checkbox"/> Rest | <input type="checkbox"/> Lying face up | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Typing | <input type="checkbox"/> Scooping | <input type="checkbox"/> House chores | <input type="checkbox"/> Exercise | <input type="checkbox"/> Lying face down | <input type="checkbox"/> Stair stepping |

Relieving Factors (check all that apply):

- | | | | | |
|--------------------------------------|-------------------------------------|--------------------------------|---|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Lying | <input type="checkbox"/> Knees bent up | <input type="checkbox"/> Support |
| <input type="checkbox"/> No movement | <input type="checkbox"/> Movement | <input type="checkbox"/> Heat | <input type="checkbox"/> Ice | <input type="checkbox"/> Analgesic topical |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Medication | <input type="checkbox"/> Rest | <input type="checkbox"/> Strengthening/Exercise | <input type="checkbox"/> Adjustments |

Chief Complaint #2: _____

Onset/Approximate Onset Date: ____ / ____ / ____ What percent of the day do you feel symptoms? ____%

Pain Level (0 = no pain, 10 = worst imaginable pain): 0 1 2 3 4 5 6 7 8 9 10

How did the condition occur? _____

Quality (check all that apply):

- | | | | | | |
|-----------------------------------|-----------------------------------|------------------------------------|-----------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Dull | <input type="checkbox"/> Sharp | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Burning | <input type="checkbox"/> Deep | <input type="checkbox"/> Aching |
| <input type="checkbox"/> Tingling | <input type="checkbox"/> Stabbing | <input type="checkbox"/> Cramping | <input type="checkbox"/> Numbness | <input type="checkbox"/> Radiating | <input type="checkbox"/> Stiffness |

Aggravating Factors (check all that apply):

- | | | | | | |
|-------------------------------------|---------------------------------------|---------------------------------------|------------------------------------|--|---|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Walking | <input type="checkbox"/> Bending | <input type="checkbox"/> Stooping | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Coughing | <input type="checkbox"/> Straining | <input type="checkbox"/> Reaching | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Looking up | <input type="checkbox"/> Looking down | <input type="checkbox"/> Movement | <input type="checkbox"/> Rest | <input type="checkbox"/> Lying face up | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Typing | <input type="checkbox"/> Scooping | <input type="checkbox"/> House chores | <input type="checkbox"/> Exercise | <input type="checkbox"/> Lying face down | <input type="checkbox"/> Stair stepping |

Relieving Factors (check all that apply):

- | | | | | |
|--------------------------------------|-------------------------------------|--------------------------------|---|--|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Lying | <input type="checkbox"/> Knees bent up | <input type="checkbox"/> Support |
| <input type="checkbox"/> No movement | <input type="checkbox"/> Movement | <input type="checkbox"/> Heat | <input type="checkbox"/> Ice | <input type="checkbox"/> Analgesic topical |
| <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Medication | <input type="checkbox"/> Rest | <input type="checkbox"/> Strengthening/Exercise | <input type="checkbox"/> Adjustments |

Chief Complaint #3: _____

Onset/Approximate Onset Date: ____ / ____ / ____ What percent of the day do you feel symptoms? ____%

Pain Level (0 = no pain, 10 = worst imaginable pain): 0 1 2 3 4 5 6 7 8 9 10

How did the condition occur? _____

Quality (check all that apply):

- Dull Sharp Throbbing Burning Deep Aching
- Tingling Stabbing Cramping Numbness Radiating Stiffness

Aggravating Factors (check all that apply):

- Sitting Standing Walking Bending Stooping Lifting
- Sleeping Sneezing Coughing Straining Reaching Twisting
- Looking up Looking down Movement Rest Lying face up Driving
- Typing Scooping House chores Exercise Lying face down Stair stepping

Relieving Factors (check all that apply):

- Sitting Standing Lying Knees bent up Support
- No movement Movement Heat Ice Analgesic topical
- Ibuprofen Medication Rest Strengthening/Exercise Adjustments

Review of Systems

Musculoskeletal:

- Osteoporosis Arthritis Scoliosis Neck pain Back problems Hip disorders
- Knee injuries Foot/ankle pain Shoulder problems Elbow/wrist pain TMJ issues Poor posture

I DENY having any of the symptoms or problems listed below.

Neurovascular:

- Anxiety Depression Headache Dizziness Pins and needles Numbness

I DENY having any of the symptoms or problems listed below.

Cardiovascular:

- High blood pressure Low blood pressure High cholesterol Poor circulation Angina Excessive bruising

I DENY having any of the symptoms or problems listed below.

Respiratory:

- Asthma Apnea Emphysema Hay fever Shortness of breath Pneumonia

I DENY having any of the symptoms or problems listed below.

Digestive:

- Anorexia/bulimia Ulcer Food sensitivities Heartburn Constipation Diarrhea

I DENY having any of the symptoms or problems listed below.

Sensory:

- Blurred vision Ringing in ears Hearing loss Chronic ear infection Loss of smell Loss of taste

I DENY having any of the symptoms or problems listed below.

Integumentary:

- Skin cancer Psoriasis Eczema Acne Hair loss Rash

I DENY having any of the symptoms or problems listed below.

Endocrine:

- Thyroid issues Immune disorders Hypoglycemia Frequent infection Swollen glands Low energy

I DENY having any of the symptoms or problems listed below.

Genitourinary:

- Kidney stones Infertility Bedwetting Prostate issues Erectile Dysfunction PMS symptoms

I DENY having any of the symptoms or problems listed below.

Constitutional:

- Fainting Low libido Poor appetite Fatigue Sudden weight gain/loss Weakness

I DENY having any of the symptoms or problems listed below.

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

Father has / had : _____ no significant disease alive deceased
Mother has / had : _____ no significant disease alive deceased
Paternal grandfather has / had : _____ no significant disease alive deceased
Paternal grandmother has / had : _____ no significant disease alive deceased
Maternal grandfather has / had : _____ no significant disease alive deceased
Maternal grandmother has / had : _____ no significant disease alive deceased
Sibling(s) has / had : _____ no significant disease alive deceased

Social History

Consumption Information:

How much alcohol do you consume daily? _____
How many cups of coffee do you drink daily? _____
How much soda do you drink daily? _____
How much water do you drink daily? _____
How much do you depend on pain relievers? _____
Do you use recreational drugs? _____

Smoking History

Do you smoke?

Currently daily Currently occasionally Former Never Heavy pipe Light pipe

If you do currently smoke, how many years have you smoked? _____

If you do currently smoke, how many packs per day do you smoke? _____

If you smoked in the past, how long has it been since you quit smoking? _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: ____/____/____

Patient's Signature: _____ Date: ____/____/____