PINNACLE SPORTS PERFORMANCE AND REHABILITATION PATIENT HISTORY FORM

Name: _____ Date: _____ DOB: _____

Chief Complaint:

Pain in: □ Head □ Neck □ Shoulder □ Arm □ Mid back
□ Low back □ Buttock □ Leg □ Other_____

History of Present Illness:

When did your pain begin?_____ □ work-related?
How did your pain begin?
□ No apparent reason □ Bending □ Lifting □ Fall
□ Motor Vehicle Accident □ Other_____
Have you had a similar episode before? □ Yes □ No
What have you been told is wrong? _____

Prior tests for your pain:

Test/Results:
□ X-ray_____
□ MRI_____
□ CT_____
□ Lab_____
□ Other_____

Prior treatment for your current problem:

Anti-inflammatory: □ Ibuprofen □ Aleve □ Celebrex □ Mobic
□ Other_____ Results: _____
Steroids: □ Cortisone pills □ Cortisone injection
□ Other_____ Results: _____
Other medications: _____ Results: _____
Injections: □ Epidural □ Facet □ Other Results: _____
Spinal surgery: □ Year/Procedures/Results_____
Physical therapy: □ Year/Procedures/Results_____
Chiropractic: □ Year/Procedures/Results_____
Other Treatments: □ Year/Type/Results _____
Has your pain : □ Improved □ Worsened □ Not changed
Is your pain: □ Constant □ Intermittent

How do the following affect your pain?

	Worse	Better	No change
Cough/sneeze	□	□	□
Sitting	□	□	□
Sit to Stand	□	□	□
Bending forward	□	□	□
Morning	□	□	□
Lifting	□	□	□
Bending backward	□	□	□
Standing	□	□	□
Walking	□	□	□
Lying on stomach	□	□	□
Nighttime	□	□	□
Looking down	□	□	□
Looking up	□	□	□
Turning head	□	□	□

What level would you rate your pain right now? (please circle)
None 0 1 2 3 4 5 6 7 8 9 10 Most severe

Family Medical History: □ Heart disease □ Cancer □ Lupus □ Diabetes
□ Arthritis □ Abnormal bleeding □ Muscle disease □ Scoliosis
□ Rheumatoid Arthritis □ Drug allergies □ Other _____
Living parents? Mother □ Yes □ No; Died at age _____ of _____
Father □ Yes □ No; Died at age _____ of _____

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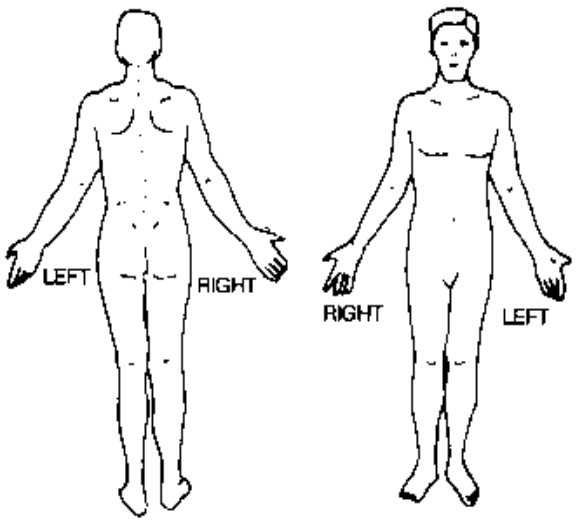
Please fill out the pain drawing below

Use these symbols on the drawings:
>>>> Ache **□ □ □ □ Numbness**
X X X X Burning **0 0 0 0 Pins and Needles**
//////// Stabbing



Name: _____ Date: _____ DOB: _____

Current Work Status:

Employer _____ Job Title_____ Time at this position _____

□ Regular Duty □ Modified Duty - Date began:_____ □ Off work – Date began:_____

Description of your Normal Job Activities

	Sitting	Standing	Walking	Driving	Lifting
Total hours in a normal work day					
Max. time at one time at work					

* If lifting at work, what is the average weight? _____lbs. How many times per hour? _____

Lifestyle Habits:

□ Tobacco _____ (# of cigs/day) □ Sleep _____ (hours/day)

How long have you smoked? _____ (years)

□ Alcohol _____ (# of drinks/day) □ Caffeine beverages _____ (#/day)

Are you currently exercising regularly? □ Yes; how long: _____

□ No; last regular exercise:_____

Has your condition prevented you from doing exercise? □ Yes □ No

Past Medical History:

□ Cancer □ Arthritis □ Alcoholism □ Kidney disease
□ Diabetes □ Seizures □ Lung Disease □ Thyroid Disease
□ Ulcers □ Glaucoma □ Heart Disease □ Tuberculosis
□ AIDS/HIV □ Hepatitis □ Diverticulitis □ High Blood Pressure
□ Stroke □ Anemia □ Pacemaker □ Joint Replacement
□ Blood Thinners □ Depression/Anxiety
□ Other_____

Surgeries/Hospitalizations:

_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

Injuries/Fractures/Dislocations:

_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

List all medications you are currently taking:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Drug Allergies: □ No □ Yes; _____

Review of Systems: (Please check all that apply):

Constitutional: □ Fever □ Night sweats □ Unexplained weight loss
Eyes: □ Abrupt change in vision
Ears, Mouth, and Throat: □ Abrupt change in hearing □ Difficulty swallowing □ Sore throat
Cardiovascular: □ Chest Pain □ Poor circulation
Respiratory: □ Cough □ Difficulty breathing
Gastrointestinal: □ Nausea □ Vomiting □ Bleeding □ Diarrhea
Musculoskelatal: □ Pain/swollen joints
Skin □ Rash
Neurologic: □ Dizziness □ Numbness □ Muscle weakness
Endocrine: □ Hot flashes
Hematologic/Lymphatic: □ Bruise easy
Allergic/Immunologic: □ Allergies to pollen, etc
Genitourinary: □ Burning on urination □ Loss of bladder/bowel control
Infection (recent): □ Urinary tract □ Respiratory □ Skin □ Immune system dysfunction □ Other _____
Psychosocial: □ Depression □ Anxiety □ Difficulty sleeping

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