



Spencer Sterling, D.P.M.
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Lakewood CA 90712
562-200-0334



FOR OFFICE USE

VITALS: HT: _____ WT: _____ BMI: _____ BP: _____ RESP: _____ TEMP: _____ PULSE: _____

PATIENT NAME: First: _____ Last: _____ DATE OF SURGERY: _____

HISTORY OF PRESENT ILLNESS

What part(s) of the body was/were injured? _____

Date of injury? _____ Do you have any current work restrictions? ☐ Full Duty ☐ With Restrictions ☐ Not Working

How did the injury/accident/condition happen? (mechanism of injury) _____

CURRENT COMPLAINTS

1. Do you have any pain? ☐ Yes ☐ No (If no pain, skip to question # 7) Where: _____

Circle one: **NO PAIN** **MOST PAIN**
Rate the intensity of your pain today
0 1 2 3 4 5 6 7 8 9 10
No Pain Mild Symptoms Moderate Symptoms Severe Debilitating

Are you physically able to perform your regular duties? If yes, please tell us the percentage.

☐ 0% - 25%; ☐ 26 - 50%; ☐ 51 - 75%; ☐ 76 - 100% or ☐ All of my regular job duties.

2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☐ Pins and Needles ☐ Numbness and Tingling ☐ No Pain

Other, explain _____

3. Did any of these symptoms exist prior to your injury/illness? ☐ Yes ☐ No Explain: _____

4. Does your present pain radiate? ☐ Yes ☐ No How often? _____ Where? _____

5. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☐ Constant

6. Activity or position that makes the pain worse _____ less _____

7. Have you received therapy for this injury? ☐ Yes ☐ No if yes, write down the % of improvement.

Physical Therapy # visits _____ Acupuncture # visits _____ Chiropractic # visits _____

(☐ 0 - 24% ☐ 25-50% ☐ 51-75% ☐ 76-100%) (☐ 0 - 24% ☐ 25-50% ☐ 51-75% ☐ 76-100%) (☐ 0 - 24% ☐ 25-50% ☐ 51-75% ☐ 76-100%)

8. Were you given a Home Exercise program? ☐ Yes ☐ No ☐ Improvement ☐ No improvement ☐ Worsened

9. Have you had any injections? ☐ Yes ☐ No ☐ If yes, how many? _____ Where? _____

How much relief did you get? ☐ 0% - 24% ☐ 25% - 50% ☐ 51% - 75% ☐ 76% - 100%

10. Have you had an MRI or CT scan? ☐ Yes ☐ No Date of MRI/CT: _____

List below any doctors (outside of US HealthWorks-Concentra) that you have seen for this injury

Name of clinician and Specialty: _____ Date: _____

Name of clinician and Specialty: _____ Date: _____

HISTORY OF PREVIOUS INJURIES

Any prior injuries to the same body part? ☐ Y ☐ N If yes, please explain _____

Have you ever had recurrent illnesses or major injuries? ☐ Yes ☐ No If yes, explain: _____

OCCUPATIONAL HISTORY

Occupational title: _____

What are your occupational duties? _____



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PAST MEDICAL HISTORY

Any previous medical conditions? ☐ High blood pressure, ☐ Diabetes, ☐ Cardiac, ☐ Pulmonary, ☐ Renal, ☐ Gastrointestinal disorders or ☐ None

SURGICAL HISTORY:

Operation

Surgeon & City

Date

MEDICATION ALLERGIES

IF NONE ☐

Reaction: ☐ Rash ☐ Upset Stomach ☐ Wheezing ☐ Shock ☐ Other _____

Reaction: ☐ Rash ☐ Upset Stomach ☐ Wheezing ☐ Shock ☐ Other _____

MEDICATIONS CURRENTLY TAKING

NAME OF MEDICATION

DOSAGE AND FREQUENCY

NAME OF MEDICATION

DOSAGE AND FREQUENCY

Are you currently taking medication for this injury? ☐ Yes ☐ No If Yes, has there been ☐ Improvement ☐ No Improvement

SOCIAL HISTORY:

SPORTS & HOBBIES _____ *MARITAL STATUS:* ☐ Married ☐ Single ☐ Divorced

Do you use tobacco in any way? If 'Yes' state type and quantity per day. ☐ Yes ☐ No _____

Do you consume alcohol? If 'Yes', state type and quantity. ☐ Yes ☐ No _____

FAMILY HISTORY:

Have any of your direct relatives suffered from ☐ blood diseases, ☐ cancer, ☐ leukemia, ☐ diabetes, ☐ heart disease, ☐ high blood pressure, ☐ strokes, ☐ mental illnesses, or ☐ other _____

REVIEW OF SYSTEMS Have you had, or commonly have any of the following?

CONSTITUTIONAL: ☐ Fever ☐ chills ☐ weakness ☐ fatigue ☐ body aches ☐ appetite loss ☐ weight gain ☐ weight loss ☐ none

SKIN: Skin diseases or problems, ☐ color changes ☐ cancer ☐ tumors ☐ cysts ☐ None ☐ other _____

HEAD: ☐ Trauma ☐ injuries ☐ frequent headaches ☐ severe headaches ☐ none ☐ other _____

EYES: ☐ Trauma ☐ injuries ☐ infections ☐ pain ☐ burning ☐ itching ☐ light sensitivity ☐ none ☐ other _____

EAR, NOSE, THROAT: ☐ Decreased hearing ☐ pain ☐ infection ☐ discharge ☐ hoarseness ☐ sinus problems ☐ recurrent throat problems
☐ voice change or ☐ dental disease ☐ none ☐ other _____

CARDIOVASCULAR: ☐ palpitations ☐ shortness of breath ☐ chest pain/pressure ☐ swelling in legs/feet or ankles ☐ varicose veins
☐ none ☐ other _____

RESPIRATORY: ☐ chronic/frequent coughing ☐ coughing of blood ☐ none ☐ other _____

GASTROINTESTINAL: ☐ Abdominal pain ☐ frequent indigestion ☐ reflux ☐ nausea ☐ vomiting ☐ ulcers ☐ black stools ☐ diarrhea
☐ constipation ☐ hemorrhoids ☐ diverticulitis ☐ liver disease ☐ none ☐ other _____

GENITOURINARY: ☐ Blood in urine ☐ painful urination ☐ difficult urination ☐ frequent urination ☐ none ☐ other _____
Are you pregnant? ☐ Yes ☐ No Last menstrual period? _____

MUSCULOSKELETAL: ☐ Joint pain ☐ neck pain ☐ back pain ☐ broken bones ☐ other musculoskeletal problems ☐ none ☐ other _____

NEUROLOGICAL: ☐ Dizziness ☐ weakness ☐ numbness ☐ convulsions ☐ other neurological problems ☐ none ☐ other _____

PSYCHIATRIC: ☐ nervousness ☐ mood swings ☐ sleep disturbances ☐ none ☐ other _____

ENDOCRINE: ☐ Increased thirst ☐ Increased appetite ☐ increased urination ☐ hair loss ☐ none ☐ other _____

BLOOD DISORDERS, CANCER: ☐ spontaneous/easy bleeding ☐ spontaneous/easy bleeding of gums ☐ easy bruising ☐ cancer ☐ spontaneous nose bleeding ☐ none ☐ other _____



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ACTIVITIES OF DAILY LIVING

Are you able to do the following daily activities? Please answer each question once with an X in the appropriate column. Note that these questions should be answered as they pertain to your activities of daily living based on your current injury.

Dress yourself including shoes	☐ Yes	☐ No	☐ N/A	_____
Wash and dry yourself	☐ Yes	☐ No	☐ N/A	_____
Take a bath	☐ Yes	☐ No	☐ N/A	_____
Get on and off the toilet	☐ Yes	☐ No	☐ N/A	_____
Cut your food	☐ Yes	☐ No	☐ N/A	_____
Lift a full cup to your mouth	☐ Yes	☐ No	☐ N/A	_____
Make a meal	☐ Yes	☐ No	☐ N/A	_____
Write a note	☐ Yes	☐ No	☐ N/A	_____
Type a message on a computer	☐ Yes	☐ No	☐ N/A	_____
Use a telephone	☐ Yes	☐ No	☐ N/A	_____
Work outdoors on flat ground	☐ Yes	☐ No	☐ N/A	_____
Climb up 1 flight of stairs (10 steps)	☐ Yes	☐ No	☐ N/A	_____
Stand	☐ Yes	☐ No	☐ N/A	_____
Sit	☐ Yes	☐ No	☐ N/A	_____
Recline	☐ Yes	☐ No	☐ N/A	_____
Rise from a chair	☐ Yes	☐ No	☐ N/A	_____
Run errands	☐ Yes	☐ No	☐ N/A	_____
Light housework	☐ Yes	☐ No	☐ N/A	_____
Feel what you touch	☐ Yes	☐ No	☐ N/A	_____
Open car doors	☐ Yes	☐ No	☐ N/A	_____
Turn faucets on and off	☐ Yes	☐ No	☐ N/A	_____
Get in and out of a car	☐ Yes	☐ No	☐ N/A	_____
Sleep	☐ Yes	☐ No	☐ N/A	_____
Engage in sexual activity	☐ Yes	☐ No	☐ N/A	_____

Patient Signature _____

Date _____

Clinician Signature _____

Date _____



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PATIENT NAME: First: _____ Last: _____ DATE OF SURGERY: _____

Since your last visit with the doctor

1. **How do you feel?** ☐ Better ☐ Same or ☐ Worse

2. What does the pain feel like? ☐ Dull ☐ Sharp ☐ Burning ☐ Throbbing ☐ Pins & Needles ☐ Numbness & Tingling ☐ No Pain

Circle one: **NO PAIN** **MOST PAIN**
 Rate the intensity of your pain today

0 1 2 3 4 5 6 7 8 9 10
 No Pain Mild Symptoms Moderate Symptoms Severe Debilitating

Are you physically able to perform your regular duties? If yes, please tell us the percentage.

☐ 0% - 25%; ☐ 26 - 50%; ☐ 51 - 75%; ☐ 76 - 100% or ☐ All of my regular job duties.

3. How often do you feel the pain? ☐ Rare ☐ Occasional ☐ Intermittent ☐ Constant

4. Activity or position that makes the pain; worse _____ better: _____

5. Have you experienced any new symptoms since your last visit? ☐ Yes ☐ No If yes, explain: _____

6. Have you followed your treatment plan as indicated? ☐ Yes ☐ No 7a. If not, please explain why _____

7. Is your treatment helping? ☐ Yes ☐ No

8. What medications are you currently taking for this injury?

Name: _____ For how long? _____ ☐ Improvement ☐ No Improvement

Name: _____ For how long? _____ ☐ Improvement ☐ No Improvement

9. Have you received therapy for this injury? ☐ Yes ☐ No If yes, write down the % of improvement.

Physical Therapy # visits _____ Acupuncture # visits _____ Chiropractic # visits _____
 (☐ 0 - 24% ☐ 25-50% ☐ 51-75% ☐ 76-100%) (☐ 0 - 24% ☐ 25-50% ☐ 51-75% ☐ 76-100%) (☐ 0 - 24% ☐ 25-50% ☐ 51-75% ☐ 76-100%)

10. Were you given a Home Exercise Program? ☐ Yes ☐ No. ☐ Improvement ☐ No improvement ☐ Worsened

11. Have you had any injections? ☐ Yes ☐ No If yes, how many? _____ Where _____

12. Did the injection relieve your symptoms? ☐ 0 - 24% ☐ 25-50% ☐ 51-75% ☐ 76-100%

13. Have you had an MRI or CT scan? ☐ Yes ☐ No Date of MRI/CT: _____

14. **PAST MEDICAL HISTORY:** Any previous medical conditions? ☐ High blood pressure, ☐ Diabetes, ☐ Cardiac, ☐ Gastrointestinal disorders.

15. Any prior injuries to the same body part? ☐ Y ☐ N If yes, please explain _____

16. Do you have any of the following conditions or illnesses? ☐ None

CONSTITUTIONAL: ☐ Fever, ☐ chills, ☐ fatigue, ☐ body aches, ☐ weight gain or ☐ weight loss, ☐ none.

CARDIOVASCULAR: ☐ Palpitations, ☐ shortness of breath, ☐ chest pain/pressure, ☐ high blood pressure ☐ swelling in legs/feet ☐ none.

RESPIRATORY: ☐ Asthma, ☐ frequent coughing, ☐ bronchitis, ☐ tuberculosis, ☐ shortness of breath, ☐ coughing of blood, ☐ none.

SKIN: ☐ Skin diseases or problems, ☐ color changes, ☐ cancer, ☐ tumors, ☐ cysts, ☐ none, ☐ other _____

MUSCULOSKELETAL: ☐ Joint pain, ☐ neck or ☐ back pain, ☐ broken bones, ☐ none.

NEUROLOGICAL: ☐ Dizziness, ☐ muscle weakness, ☐ numbness, ☐ tingling, ☐ none.

OTHER CHANGES: Please explain _____

Patient Signature _____ Date _____

Clinician Signature _____ Date _____