Today's Date: _____

Medical History

Name: _____ **DOB:** _____ **Height:** _____ **Weight:** _____

Primary Care Provider: _____

Referred By (Circle One): Friend Relative Internet Insurance Doctor: _____

Race: _____ **Ethnicity:** _____

Current Condition **(You must complete all questions below as they may be required in order to obtain authorization from your insurance company for continued treatment(s).)**

Reason For Visit Today (Briefly Describe Condition): _____

_____

_____

Please specify which side: Left Right Both

Dominant Hand: Left Right Ambidextrous

How would you describe your pain? (Circle all that apply): Throbbing Dull Shooting Weak Stabbing Achy Sharp Difficult to Describe Numbness Tingling Popping Buckling Locking Swelling Stiffness Grinding Giving Way Discharge Discoloration Worse at Night

Severity of symptoms (Circle One): Mild Moderate Severe

Pain Scale 0-10: _____

Timing (Circle One): Constant Intermittent Varies with Activities

How long ago did the problem start? _____

Were you seen in the ER? (Circle One): Yes No If yes, which ER? _____

Was there an injury? (Circle One): Yes No If yes, explain: _____

_____

Any imaging in the past 6 months for this issue? (X-Rays, MRI, CT, Etc.) (Circle One): Yes No

If yes, where was this done? (Banner Imaging, SimonMed, etc.) : _____

We are only able to retrieve actual images from SimonMed, SMIL, and certain Arizona Diagnostic Radiology locations. If you have had imaging performed at a different imaging facility, please bring a copy of imaging along with you to your appointment.

Do you have difficulty performing tasks at work or around the house? (Circle One): Yes No

If yes, explain: _____

Do you have difficulty getting dressed (socks, shoes, pants, etc.)? (Circle One): Yes No

At most, how LONG can you walk without difficulty?

Cannot Walk < 5 Mins. <15 Mins. <30 Mins <60 Mins No Limit

At most, how FAR can you walk without difficulty?

Cannot Walk Unable to Walk Through Grocery Store No Limit

<1/4 Mile (2 Blocks) <1 Mile <5 Miles

Medical History

Do any of the following improve or worsen your symptoms? (Circle One For Each)

Ace Wrap	Improves	Worsens	Has No Affect	Does Not Apply
Bracing	Improves	Worsens	Has No Affect	Does Not Apply
Cold	Improves	Worsens	Has No Affect	Does Not Apply
Elevation	Improves	Worsens	Has No Affect	Does Not Apply
Heat	Improves	Worsens	Has No Affect	Does Not Apply
Kneeling	Improves	Worsens	Has No Affect	Does Not Apply
Lying Down	Improves	Worsens	Has No Affect	Does Not Apply
Running	Improves	Worsens	Has No Affect	Does Not Apply
Squatting	Improves	Worsens	Has No Affect	Does Not Apply
Stairs	Improves	Worsens	Has No Affect	Does Not Apply
Standing	Improves	Worsens	Has No Affect	Does Not Apply
Throwing	Improves	Worsens	Has No Affect	Does Not Apply
Walking	Improves	Worsens	Has No Affect	Does Not Apply
Other: _____	Improves	Worsens	Has No Affect	Does Not Apply

Please indicate any interventions you have tried and if they have made the issue better or worse:

Activity Modification

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name): _____

NSAIDs (Aleve, Ibuprofen, Diclofenac, Meloxicam, etc.)

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name): _____

Assistive Devices (Cane, Walker, Etc.)

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name): _____

Chiropractic

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name): _____

Home Exercises

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name): _____

Medical History

OTC Meds- Herbal/Homeopathic/Supplements

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name): _____

Other Injections (Hyaluronic Acid, Etc.)

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name): _____

Physical Therapy

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name): _____

Steroid Injections (Cortisone)

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name): _____

Other: _____

Have Not Tried Improved Did Not Improve Made Worse

Tried for: Less Than 3 Months More Than 3 Months

Prescribed/Recommended By (Doctor's Name): _____

If you have ever been told you have any of the following conditions, please use (✓) to select box to the right of the condition.

If you have **NO** past medical history, **PLEASE (✓)** here: ☐

Alcoholism		Gout		Mental Illness	
Anemia		Heart Attack		Neurological Disorder	
Anxiety		Heart Rhythm Problem		Neuropathy	
Asthma		Heart Valve Problem		Osteoarthritis	
Bleeding Disorder		Hepatitis		Polio	
Blood Clots		HIV/AIDS		Rheumatoid Arthritis	
Blood Transfusion		Hypertension		Seizures	
Bronchitis		Hypothyroidism		Stroke	
COPD		Inflammatory Bowel		Tuberculosis	
Currently Pregnant		Kidney Disease		Urinary Infections	
Depression		Low Back Pain			
Diabetes		Lung Disease			

Please give details on anything you've checked above: _____

_____

Cancer: What type and how long ago? _____

Medical History

Surgeries ☐ NONE

Year	Reason

Past Hospitalization History:

☐ Surgery ☐ Severe Illness ☐ Pregnancy ☐ No Significant Hospitalization

Drug Allergies ☐ NONE

Name	Reaction

Medication ☐ NONE

Medication Name/ Strength (mg)	Frequency

Family History

Family History of: ☐Anesthesia Problems ☐Abnormal Blood Clots ☐Abnormal Bleeding

Please List All Major Medical Problems for the Following Family Members:

Father: _____

Mother: _____

Sister: _____

Brother: _____

Children: _____

Medical History

Social History

Employer: _____ Occupation: _____

Marital Status: ☐Single ☐Divorced ☐Widowed ☐Married/Partner Name: _____

Caffeine Use: ☐Tea Intake ☐Coffee Intake ☐Soda Intake ☐Energy Drinks
How many drinks per day?: _____

Alcohol Use: ☐Rarely ☐Daily ☐Socially ☐Never ☐Recovering Alcoholic
How many drinks per day?: _____

Recreational Drugs: ☐Never ☐Currently ☐In the Past ☐None
If yes, what drug(s)?: _____

Smoking: ☐Never ☐Former ☐Currently: How many per day? _____ Years? ____

Symptoms

Are you currently experiencing any of the following? **Please use (✓) to select appropriate box(es).**

Fevers		Vision Changes		Nausea/ Vomiting	
Fatigue		Glasses/Contacts		Painful/Frequent Urination	
Weight Gain		Dry Eyes		Cold Intolerance	
Weight Loss		Nose Bleeding		Hair Loss	
Excess Stress		Cough		Excess Hair	
Blistering		Shortness of Breath		Excess Sweating	
New/Changing Growths		Wheezing		Irregular Periods	
Thinning Hair		Chest Pain		Joint Pain/Arthritis	
Nail Changes		Congestive Heart Failure		Muscle Weakness	
Keloids		Leg Swelling		Anemia	
Cold Sores		Fast/Irregular Heart Beat		Blood Clots	
Dry Skin		Poor Circulation		Enlarged Lymph Nodes	
Dry Lips		Abdominal Pain		Frequent Infections	
Sun Sensitivity		Constipation		Environmental Allergies	
Pigment Change		Diarrhea			
Rash		Change in Appetite			

Have you experienced or had any of the following previously? **Circle yes or no:**

Blood Clot in your legs or lungs?	Yes	No
Problems with excessive bleeding?	Yes	No
Latex allergy?	Yes	No
Problems with anesthesia?	Yes	No
MRSA infection?	Yes	No
Sleep apnea?	Yes	No
Adhesive allergies/skin irritation?	Yes	No
Excessive swelling after surgery?	Yes	No
Previous wound healing issues?	Yes	No
C-Spine surgery?	Yes	No
Metal allergies?	Yes	No