Elevate Sport & Spine Therapy

Name_____ **Date**_____ **DOB**_____

Chief Complaint:

Why are you here to see the doctor today?

_____

_____

_____

Current Average Pain Level: (Please Circle)

None - 0 1 2 3 4 5 6 7 8 9 10 - Most Severe

History of Present Illness:

When/how did your pain begin?

_____

_____

_____

_____

Prior Treatment for Your Current Problem:

Have you been seen by anyone else for this issue?_____

If so, who did you see?_____

Have you had this same problem in the past?_____

If so, how did it resolve?_____

_____

Goals and Outcomes:

Does your pain interfere with any daily activities? _____

If so, please list them:_____

_____

_____

What are your goals for treatment?_____

_____

_____

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How do the following affect your condition?

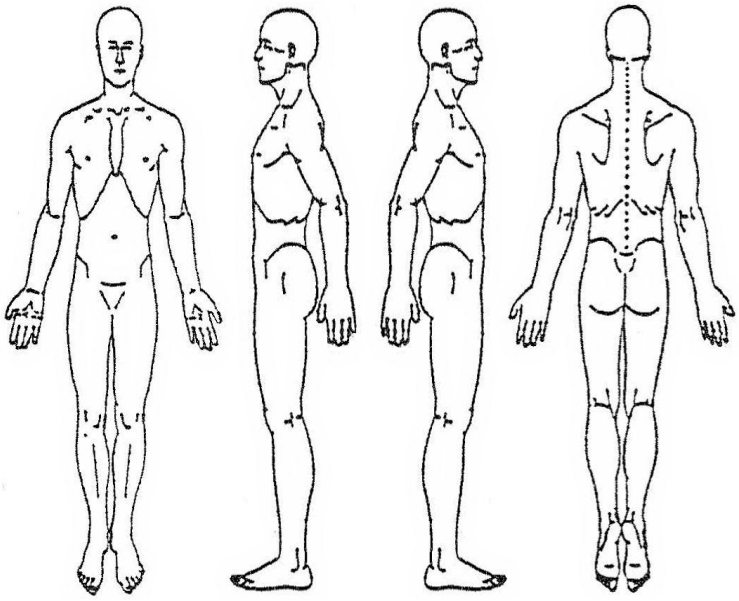
	Worse	Better	Same
Cough/Sneeze:	[ ]	[ ]	[ ]
Sitting:	[ ]	[ ]	[ ]
Sit to Stand:	[ ]	[ ]	[ ]
Bending Forward:	[ ]	[ ]	[ ]
Morning:	[ ]	[ ]	[ ]
Lifting:	[ ]	[ ]	[ ]
Bending Backward:	[ ]	[ ]	[ ]
Standing:	[ ]	[ ]	[ ]
Walking:	[ ]	[ ]	[ ]
Lying down:	[ ]	[ ]	[ ]
Nighttime:	[ ]	[ ]	[ ]
Turning Head:	[ ]	[ ]	[ ]

Barriers

Are there any limitations that may keep you from following a treatment plan? If so, describe:_____

_____

Please Fill Out the Pain Drawing Below:



>>>> Ache ZZZZ Numbness XXXX Burning

0000 Pins and Needles //// Stabbing

Elevate Sport & Spine Therapy

Family Medical History: [ ] Heart Disease [ ] Cancer
[ ] Auto-Immune [ ] Abnormal Bleeding [ ] Diabetes
[ ] Muscle Disease [ ] Scoliosis [ ] Arthritis [ ] RA
[ ] Other_____
Living Parents? Mother [ ] Yes [ ] No; Age_____
Father [ ] Yes [ ] No; Age_____

Current Work Status:
[ ] Regular Duty [ ] Limited/Light Duty Since_____
[ ] Off Work Since_____

Lifestyle Habits:
[ ] Tobacco_____ (Pks/Day) [ ] Sleep_____(Hrs/Day)
[ ] Alcohol_____(Drinks/Day)
Do You Regularly Exercise?
[ ] Yes; Frequency_____ Duration_____
[ ] No; Last Regular Exercise_____
[ ] My Condition Currently Prevents Me From Exercising

Past Medical History:
[ ] Cancer [ ] Arthritis [ ] Alcoholism [ ] Kidney Disease
[ ] Diabetes [ ] Seizures [ ] Lung Disease [ ] Thyroid
[ ] Ulcers [ ] Glaucoma [ ] Heart Disease [ ] Tuberculosis
[ ] AIDS/HIV [ ] Hepatitis [ ] Hernia [ ] Hypertension
[ ] Stroke [ ] Anemia [ ] Pace Maker [ ] Blood Thinners
[ ] Other_____
[ ] Implants_____

Surgeries/Hospitalizations:
Reason_____Year_____
Reason_____Year_____
Reason_____Year_____
Complications_____

Inury/Fracture/Dislocation:
_____Year_____
_____Year_____
_____Year_____

Current Medications (include any in last 6 months):
_____
_____
_____

Review of Systems: (Please check all that apply)

Constitutional: [ ] Fever [ ] Night Sweats
[ ] Unexplained Weight Loss / Gain
[ ] Excessive Fatigue
Eyes: [ ] Abrupt Change in Vision
ENT: [ ] Abrupt Change in Hearing
[ ] Difficulty Swallowing
[ ] Sore throat
[ ] Gum Bleeding/Sensitivity
Cardiovascular: [ ] Chest Pain [ ] Poor circulation
[ ] Swelling
Respiratory: [ ] Cough [ ] Difficulty breathing
GI: [ ] Nausea [ ] Vomiting [ ] Bleeding
[ ] Diarrhea [ ] Urgency [ ] Food cravings
[ ] Hemorrhoids [ ] Constipation
Musculoskelatal: [ ] Pain/swollen joints
Skin: [ ] Rash [ ] Broken capillaries
Neurologic: [ ] Dizziness [ ] Numbness
[ ] Muscle weakness
Endocrine: [ ] Hot flashes
[ ] Heat / Cold Intolerance
[ ] Excessive Hair Growth / Loss
Blood/Lymph: [ ] Bruise easy
Genitourinary: [ ] Burning on urination
[ ] Urinary frequency
[ ] Loss of bladder/bowel control
[ ] Vaginal bleeding
[ ] Uterine cramping
Infection : [ ] Urinary tract [ ] Respiratory
[ ] Skin [ ] Other_____
Immune system: [ ] Other _____
Psychosocial: [ ] Depression [ ] Anxiety
[ ] Difficulty sleeping

List Any Known Allergies:
_____
_____

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