

MEDICAL HISTORY

Patient Name: _____ DOB: _____

Type of injury: _____ Date of onset: _____

Attorney Involved: Yes No

Currently Working: Yes No

Please describe how injury occurred: _____

List any medications you are presently taking (if any): _____

Have you had x-rays taken for this injury? Yes No Have you had an MRI for this injury? Yes No

What best describes your pain: Sharp Dull Aching Shooting

What best describes your symptoms: Constant Intermittent Occasional

On a scale from 0-10, 0 being no pain and 10 being the worst pain imaginable, please rate your pain from this injury:
_____ Now _____ Best _____ Worst

What makes your pain feel worse? (circle all that apply)

What makes your pain feel better?

Sitting

Laying down

Reaching

Standing

Walking

Bending

Leaning

Stooping

Lifting

Climbing

Driving

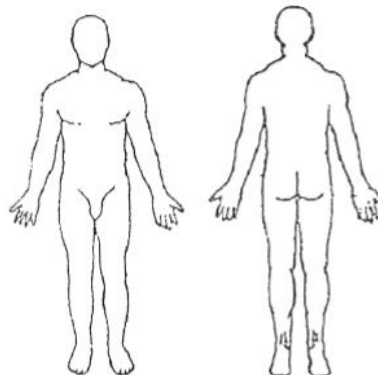
Dressing

Please mark on the diagram the location of the symptoms that you are currently feeling:

X = Pain

..... = Numbness

----- = Tingling



Please mark **Yes** or **No**:

Do you have a history of cancer? Yes No

Do you have a pacemaker? Yes No

Do you have bowel or bladder problems? Yes No

Do you have hypertension (high blood pressure)? Yes No

Do you have Diabetes Mellitus? Yes No

Have you had any significant, unplanned weight loss / gain in the past 3 months? Yes No

Do you have any allergies? Yes No

If yes please list: _____

Please list any other relevant past medical history or orthopedic history: _____