1105 Independence Drive
West Plains, Missouri. 65775
Phone: 417-372-8090
Fax: 417-256-0882

CONFIDENTIAL MEDICAL HISTORY

Left / Right / Ambidextrous Occupation: _____ Age: _____
Employer: _____How long have you worked there? _____
Current work status: (circle). Full Duty Modified Duty Not Working Retired
Restrictions: _____ Date last worked: ____ / ____ / _____

Referred by: _____Primary Care M.D: _____
Return to Physician Date:_____

What are you here to see the therapist for? _____

How did injury occur? _____

Is this work related? Y / **N** **Is this related to a car accident**? Y / N **Date of injury**: ____ / ____ / _____

Is this the date that the injury occurred, you first noticed symptoms, or you filed a claim?
_____

When and what were the first symptoms?
_____

How long have you had symptoms? _____

Whom have you seen for this condition? _____

Have you had similar problems in the past? (explain:)
_____

Frequency of Symptoms: Constant____. Frequent____. Occasional____. Intermittent____

Pain level in the past 24 hours:	**NO pain.**	**0.**	**1.**	**2.**	**3.**	**4.**	**5.**	**6.**	**7.**	**8.**	**9.** **10 Extreme pain**
Pain level in the past week.	**NO pain**	**0.**	**1.**	**2.**	**3.**	**4.**	**5.**	**6.**	**7.**	**8.**	**9.** **10 Extreme pain**
Pain at its best and worse:	**NO pain.**	**0.**	**1.**	**2.**	**3.**	**4.**	**5.**	**6.**	**7.**	**8.**	**9.** **10 Extreme pain**

If you have pain, please circle those works which best describe it. Decreased/Loss of function. Loss of balance

Sharp. Dull. Burning. Throbbing. Twinge. Ache. Numb. Tingle. Tight. Pulling. Weakness. Stiffness

What medications are you taking for this problem? Please list the name of the medications:
_____

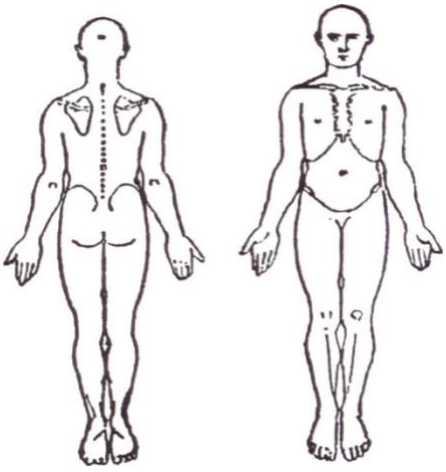
Anti-inflammatory. **Pain killer.** **Muscle relaxer.** **Other**_____

List of other medications you are currently taking: _____

Date of surgery (if applicable)_____**Type of Surgery**_____

Please indicate painful area by shading models.

X = pain / = tingling O = numbness



How do you feel in the Morning? Better/worse. Afternoon? Better/worse

Evening? Better/worse. Night? Better/worse

What positions or activities make your pain better?_____

What positions or activities make your pain worse?_____

Physical work requirements: Sedentary. Light. Moderate. Heavy. Very heavy

Job requires prolonged: Sitting. Standing. Bending. Walking. Lifting. Squatting. Driving

STUDIES AND TREATMENT

Please check any studies you have had and include dates:

X-RAY: _____MRI/CT Scan: _____EMG: _____
OTHER:_____THERAPY:_____
SPLINTS/BRACES: _____MEDICATIONS: _____
INJECTIONS: _____OTHER: _____

PREVIOUS TREATMENTS: Please check any treatment you have had and include dates, duration, & number of visits:
_____

SOCIAL & PERSONAL HISTORY:

Do you smoke tobacco products? Are you an ex-smoker? Y / N (if YES, ___ packs per day for ___ years)

How often do you drink alcohol? ___ daily ___ frequently ___occasionally ___ never

In what recreational activities do you enjoy participating?

_____

_____

MEDICAL HISTORY

MEDICAL CONDITIONS: To the best of your knowledge, have you ever had a serious medical problem related to the following?

Skin rashes or disorders Y/N	Bladder or kidneys Y/N	Lung disease Y/N
Thyroid Y/ N	HIV, Hepatitis Y/ N	Blood disorders Y/ N Osteoporosis Y/ N
Breasts Y/ N	Epilepsy or stroke Y/ N	High blood pressure Y/ N
Cancer Y/ N	Kidney Disease Y/ N	Stroke Y/N
Arthritis Joint Pain Y/N	Osteoporosis Y/N	Spine Y/N
Headaches. Y/N	Dizziness Y/N	Bowel/Bladder Issues Y/N
Diabetes Y/N	Fibromyalgia Y/N	Pacemaker Y/N
Parkinson's Y/N	Pregnant Y/N	

_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information or omitting information may be dangerous to my health. It is my responsibility to inform the doctor of any changes in my medical status with each and every visit. I also authorize the health care staff to perform the necessary services I may need.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY:

_____

PRINTED NAME OR PATIENT OR RESPONSIBLE PARTY:

_____ DATE: ____ / ____ / ____

For office use only: Height: ___'_____" Weight: _____ lbs. BMI: _____ BP: ____ /_____