



INJURY SPECIALISTS
PATIENT HISTORY FORM



*Please complete all questions
on both sides of form*

Your Name: _____ Age: _____

Whom may we thank for referring you to Injury Specialists? _____ Today's Date: _____

When did this pain begin? Month _____ Year _____ How did it start? _____ accident at home _____ accident at work
_____ auto accident _____ after an operation or other physical problem _____ No Apparent Cause

Please explain the Main Complaint which brought you to Injury Specialists: _____

Explain what occurred:

Where do you feel the pain? _____

Explain how your pain feels to you (i.e.; sharp, dull): _____

Has this pain changed since it began (i.e.; worse or better)? ___ No ___ Yes If yes, explain: _____

What makes your pain feel better? _____

What makes your pain feel worse? _____

Is your pain? ___ rarely present ___ only occurs under certain circumstances ___ frequently present ___ always present

On a scale of 0 – 10 rate your pain, where 0 means no pain and 10 means worse pain imaginable:

At Its Worst _____ At Its Least _____ Usually _____

Have you received treatment from: ___ Surgeon ___ Family Doctor ___ Chiropractor ___ Physical Therapist ___ Massage Therapist
(check all that apply)

Please explain: _____

List any past operations and/or medical procedures including when and where:

List any tests you have had performed: (MRI, CT Scan, X-rays, Blood work) including when and where:

List **ALL CURRENT** Medications including dosage and frequency; (include over the counter medications also)

LIST ALL ALLERGIES: _____

BP: _____ P: _____ R: _____ HT.: _____ WT.: _____

Do you have a family physician? ___Yes ___No **Physician's Name:** _____

Do you see him regularly? ___Yes ___No **Date of last visit** _____ **Telephone Number:** _____

Marital Status: ___Married ___Single ___Divorced ___Widowed ___Separated

Occupation: _____ **Retired** _____ (please state previous occupation)

Work Status: ___Full Time ___Part Time ___Employed but not working due to illness ___Disabled ___Unemployed

Do you smoke? ___No ___Yes **Packs per day** ___ **Do you use Recreational Drugs?** **Type** _____ **How often** _____

Do you wear a prosthetic device? ___No ___Yes/Type _____ **Are you currently Pregnant?** ___No ___Yes - # of months ___

Date of last Breast Exam: _____ **N/A:** ___ **Date of last Pap Smear:** _____ **N/A:** ___ **Date of last Prostate Exam:** _____ **N/A:** ___

FAMILY HISTORY

Diseases/Medical Conditions

Mother: ___Living ___Deceased _____

Father: ___Living ___Deceased _____

Sister(s) ___Living ___Deceased # _____

Brother(s) ___Living ___Deceased # _____

Children ___Living ___Deceased _____

Number of children: _____ **Boys:** _____ **Girls:** _____

Injury Specialists is a CARF Accredited Rehabilitation Facility and as such must ask the following questions.

Do you currently have a Living Will /Advance Directive? Yes No

Do you wish to place a copy on your chart? Yes No **Date placed on chart.**

_____/_____/_____

Are you interested in obtaining information regarding a Living Will / Advanced Directive? Yes No

Patient comments / Additional Information: _____

REVIEW OF SYSTEMS

Have you ever been treated for or recently been troubled with any of the following: Please explain your yes answers.

CONSTITUTIONAL SYMPTOMS

Fever ___No ___Yes: _____
Persistent cough ___No ___Yes: _____
Flu-like symptoms ___No ___Yes: _____
Night sweats ___No ___Yes: _____
Recent weight gain ___No ___Yes: How much_____
Recent weight loss ___No ___Yes: How much_____
Appetite changes ___No ___Yes: _____

OPHTHALMOLOGIC

Visual disturbances ___No ___Yes: _____
Loss of visual fields ___No ___Yes: _____
Redness/Tearing ___No ___Yes: _____
Wear glasses/contacts ___No ___Yes: _____
Recent prescription change ___No ___Yes: _____

EARS, NOSE, MOUTH, THROAT

Recent cough ___No ___Yes: _____
Hoarseness/Sore throat ___No ___Yes: _____
Difficulty swallowing ___No ___Yes: _____
Mouth sores ___No ___Yes: _____
Do you wear dentures ___No ___Yes: _____
 Splints ___No ___Yes: _____
 Braces ___No ___Yes: _____
Hearing impairment ___No ___Yes: _____
Ear ache/Discharge ___No ___Yes: _____
Ringing in the ears ___No ___Yes: _____
Do you wear hearing aids ___No ___Yes: _____
Sinus problems ___No ___Yes: _____

CARDIAC / VASCULAR

Heart disease ___No ___Yes: _____
High blood pressure ___No ___Yes: _____
Rheumatic fever ___No ___Yes: _____
Heart murmur ___No ___Yes: _____
Enlarged Heart ___No ___Yes: _____
Chest pain/Pressure ___No ___Yes: _____
Irregular heart beat ___No ___Yes: _____
Rapid heart beat ___No ___Yes: _____
Heart attack ___No ___Yes: _____
Mitral valve prolapse ___No ___Yes: _____
Shortness of breath ___No ___Yes: _____
Phlebitis (blood clot) ___No ___Yes: _____
Varicose veins ___No ___Yes: _____

PULMONARY

Asthma ___No ___Yes: _____
Pneumonia ___No ___Yes: _____
Bronchitis ___No ___Yes: _____
COPD/Emphysema ___No ___Yes: _____
Wheezing ___No ___Yes: _____
of pillows sleep on at night _____
Hay fever ___No ___Yes: _____

GASTROINTESTINAL

Gallstones ___No ___Yes: _____
Indigestion ___No ___Yes: _____
Nausea/Vomiting ___No ___Yes: _____
Reflux disorder ___No ___Yes: _____
Stomach ulcers ___No ___Yes: _____
Abnormal pain ___No ___Yes: _____
Diarrhea/Constipation ___No ___Yes: _____
Change in bowel habits ___No ___Yes: _____
Upset stomach w/NSAIDS ___No ___Yes: _____

