INTEGRATED
Sport, Spine & Rehab

Confidential Patient Health Record

Today's Date: ____/_____/_____

Demographic Information

First: _____ MI: _____ Last: _____ Suffix: _____

Birth Date: _____ /_____/_____ **Sex:** Male / Female / Other **Marital Status:** Single / Married / Other

Address: _____ Apt #: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

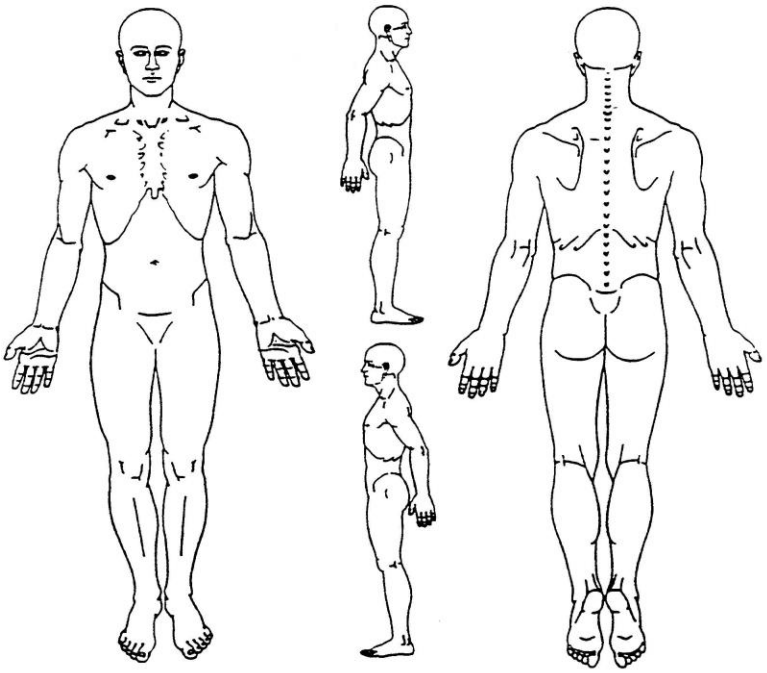
Email Address: _____ Preferred Contact Method: _____

Primary Care Provider: _____

Referral: ☐ Family _____ ☐ Friend _____ ☐ Dr. _____

☐ Internet ☐ Insurance Plan ☐ Other: _____

Problem Areas



Circle on the body diagram and add the letter which corresponds to the symptom described.

Comments can be added to describe in fuller detail.

Key:

N – Numbness	B – Burning	S – Stabbing
T – Tingling	A – Aching	P – Pain

Comments:

_____

_____

_____

_____

_____

_____

Allergies: _____

Medications (with dosages): _____

Surgeries (with dates): _____

Previous injuries and dates treated: _____

_____

***** Please fill out each area ONLY for the specific area you're wanting treated*****

Chief Complaint #1: _____

Onset/Approximate Onset Date: ____ /____/_____ What percent of the day do you feel symptoms? ____%

Pain Level (0 = no pain, 10 = worst imaginable pain): 0 1 2 3 4 5 6 7 8 9 10

How did the condition occur? _____

Quality (check all that apply):

☐ Dull	☐ Sharp	☐ Throbbing	☐ Burning	☐ Deep	☐ Aching
☐ Tingling	☐ Stabbing	☐ Cramping	☐ Numbness	☐ Radiating	☐ Stiffness

Aggravating Factors (check all that apply):

☐ Sitting	☐ Standing	☐ Walking	☐ Bending	☐ Stooping	☐ Lifting
☐ Sleeping	☐ Sneezing	☐ Coughing	☐ Straining	☐ Reaching	☐ Twisting
☐ Looking up	☐ Looking down	☐ Movement	☐ Rest	☐ Lying face up	☐ Driving
☐ Typing	☐ Scooping	☐ House chores	☐ Exercise	☐ Lying face down	☐ Stair stepping

Relieving Factors (check all that apply):

☐ Sitting	☐ Standing	☐ Lying	☐ Knees bent up	☐ Support
☐ No movement	☐ Movement	☐ Heat	☐ Ice	☐ Analgesic topical
☐ Ibuprofen	☐ Medication	☐ Rest	☐ Strengthening/Exercise	☐ Adjustments

Chief Complaint #2: _____

Onset/Approximate Onset Date: ____ /____/_____ What percent of the day do you feel symptoms? ____%

Pain Level (0 = no pain, 10 = worst imaginable pain): 0 1 2 3 4 5 6 7 8 9 10

How did the condition occur? _____

Quality (check all that apply):

☐ Dull	☐ Sharp	☐ Throbbing	☐ Burning	☐ Deep	☐ Aching
☐ Tingling	☐ Stabbing	☐ Cramping	☐ Numbness	☐ Radiating	☐ Stiffness

Aggravating Factors (check all that apply):

☐ Sitting	☐ Standing	☐ Walking	☐ Bending	☐ Stooping	☐ Lifting
☐ Sleeping	☐ Sneezing	☐ Coughing	☐ Straining	☐ Reaching	☐ Twisting
☐ Looking up	☐ Looking down	☐ Movement	☐ Rest	☐ Lying face up	☐ Driving
☐ Typing	☐ Scooping	☐ House chores	☐ Exercise	☐ Lying face down	☐ Stair stepping

Relieving Factors (check all that apply):

☐ Sitting	☐ Standing	☐ Lying	☐ Knees bent up	☐ Support
☐ No movement	☐ Movement	☐ Heat	☐ Ice	☐ Analgesic topical
☐ Ibuprofen	☐ Medication	☐ Rest	☐ Strengthening/Exercise	☐ Adjustments

Chief Complaint #3: _____

Onset/Approximate Onset Date: ____ /____/_____ What percent of the day do you feel symptoms? ____%

Pain Level (0 = no pain, 10 = worst imaginable pain): 0 1 2 3 4 5 6 7 8 9 10

How did the condition occur? _____

Quality (check all that apply):

☐ Dull	☐ Sharp	☐ Throbbing	☐ Burning	☐ Deep	☐ Aching
☐ Tingling	☐ Stabbing	☐ Cramping	☐ Numbness	☐ Radiating	☐ Stiffness

Aggravating Factors (check all that apply):

☐ Sitting	☐ Standing	☐ Walking	☐ Bending	☐ Stooping	☐ Lifting
☐ Sleeping	☐ Sneezing	☐ Coughing	☐ Straining	☐ Reaching	☐ Twisting
☐ Looking up	☐ Looking down	☐ Movement	☐ Rest	☐ Lying face up	☐ Driving
☐ Typing	☐ Scooping	☐ House chores	☐ Exercise	☐ Lying face down	☐ Stair stepping

Relieving Factors (check all that apply):

☐ Sitting	☐ Standing	☐ Lying	☐ Knees bent up	☐ Support
☐ No movement	☐ Movement	☐ Heat	☐ Ice	☐ Analgesic topical
☐ Ibuprofen	☐ Medication	☐ Rest	☐ Strengthening/Exercise	☐ Adjustments

Review of Systems

Musculoskeletal: ☐ I DENY having any of the symptoms or problems listed below.

☐ Osteoporosis ☐ Arthritis ☐ Scoliosis ☐ Neck pain ☐ Back problems ☐ Hip disorders
☐ Knee injuries ☐ Foot/ankle pain ☐ Shoulder problems ☐ Elbow/wrist pain ☐ TMJ issues ☐ Poor posture

Neurovascular: ☐ I DENY having any of the symptoms or problems listed below.

☐ Anxiety ☐ Depression ☐ Headache ☐ Dizziness ☐ Pins and needles ☐ Numbness

Cardiovascular: ☐ I DENY having any of the symptoms or problems listed below.

☐ High blood pressure ☐ Low blood pressure ☐ High cholesterol ☐ Poor circulation ☐ Angina ☐ Excessive bruising

Respiratory: ☐ I DENY having any of the symptoms or problems listed below.

☐ Asthma ☐ Apnea ☐ Emphysema ☐ Hay fever ☐ Shortness of breath ☐ Pneumonia

Digestive: ☐ I DENY having any of the symptoms or problems listed below.

☐ Anorexia/bulimia ☐ Ulcer ☐ Food sensitivities ☐ Heartburn ☐ Constipation ☐ Diarrhea

Sensory: ☐ I DENY having any of the symptoms or problems listed below.

☐ Blurred vision ☐ Ringing in ears ☐ Hearing loss ☐ Chronic ear infection ☐ Loss of smell ☐ Loss of taste

Integumentary: ☐ I DENY having any of the symptoms or problems listed below.

☐ Skin cancer ☐ Psoriasis ☐ Eczema ☐ Acne ☐ Hair loss ☐ Rash

Endocrine: ☐ I DENY having any of the symptoms or problems listed below.

☐ Thyroid issues ☐ Immune disorders ☐ Hypoglycemia ☐ Frequent infection ☐ Swollen glands ☐ Low energy

Genitourinary: ☐ I DENY having any of the symptoms or problems listed below.

☐ Kidney stones ☐ Infertility ☐ Bedwetting ☐ Prostate issues ☐ Erectile Dysfunction ☐ PMS symptoms

Constitutional: ☐ I DENY having any of the symptoms or problems listed below.

☐ Fainting ☐ Low libido ☐ Poor appetite ☐ Fatigue ☐ Sudden weight gain/loss ☐ Weakness

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

Father	has / had : _____	☐ no significant disease	☐ alive	☐ deceased
Mother	has / had : _____	☐ no significant disease	☐ alive	☐ deceased
Paternal grandfather	has / had : _____	☐ no significant disease	☐ alive	☐ deceased
Paternal grandmother	has / had : _____	☐ no significant disease	☐ alive	☐ deceased
Maternal grandfather	has / had : _____	☐ no significant disease	☐ alive	☐ deceased
Maternal grandmother	has / had : _____	☐ no significant disease	☐ alive	☐ deceased
Sibling(s)	has / had : _____	☐ no significant disease	☐ alive	☐ deceased

Social History

Consumption Information:

How much alcohol do you consume daily? _____

How many cups of coffee do you drink daily? _____

How much soda do you drink daily? _____

How much water do you drink daily? _____

How much do you depend on pain relievers? _____

Do you use recreational drugs? _____

Smoking History

Do you smoke?

☐ Currently daily ☐ Currently occasionally ☐ Former ☐ Never ☐ Heavy pipe ☐ Light pipe

If you do currently smoke, how many years have you smoked? _____

If you do currently smoke, how may packs per day do you smoke? _____

If you smoked in the past, how long has it been since you quit smoking? _____

I acknowledge that I have received the Clinic's Notice of Privacy Practices for protected health information.

Patient Print Name: _____ Date: ____/_____/_____

Patient's Signature: _____ Date: ____/_____/_____