REGENERATIVE
SPINE & JOINT CENTER

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Medical History Form

Name:_____ Today's Date: _____ (page 1 of 5)

Age:_____ Date of Birth:_____ Dominant Hand: **R** **L** Gender: **Male** **Female**

Who referred you? _____ Primary Care Physician's name? _____

① Are your symptoms related to an accident or personal injury? **YES** **NO** If yes, describe briefly: _____

② Is a lawyer involved in this issue? **YES** **NO** ③ Did a work injury cause your symptoms? **YES** **NO**

*****If YES to any of the 3 questions in this box then stop filling in this form & call our office to discuss*****

PRIMARY SYMPTOM

Where is your **PRIMARY** symptom located? _____

How long ago did your **PRIMARY** symptom begin? _____

How did your **PRIMARY** symptom begin? (circle) **Gradually** **Suddenly**

Your **PRIMARY** symptom is: (circle any) **Constant** **Intermittent** **Worsening** **Improving** **Plateaued**

Your **PRIMARY** symptom feels like: (circle any) **ache** **burning** **cold** **crampy** **dull** **hot** **hurt** **itchy** **jabbing** **numbness** **pins & needles** **pressure** **pulling** **sharp** **shooting** **sore** **stabbing** **tearing** **tender** **throbbing**

Do you have **weakness?** **YES** **NO** (if yes, is weakness **Constant** or **Intermittent** or **Posture Dependent**?)

Aggravates	No Change	Relieves	Check mark ☑ how each activity below impacts your primary symptom:
			While Sitting
			While Standing
			Moving Sit to Stand
			Walking
			Lying on Belly (prone)
			Lying on Back (supine)
			Lying on Left Side
			Lying on Right Side
			Pushing Shopping Cart
			Everything
			Nothing

Unable	Need Help	Hard But Able	No Problem	Check mark ☑ your ability to perform these Activities of Daily Living (ADLs):
				Personal Hygiene
				—bathing
				—grooming
				—oral care
				Dressing
				—shirt
				—pants
				—socks & shoes
				Eating
				Toileting
				Mobility

Circle the typical pain intensity of your primary symptom on this ten point pain scale:

(**Pain Intensity Scale:** ⓪ Represents no pain and ⑩ Represents the worst pain you can possibly imagine)

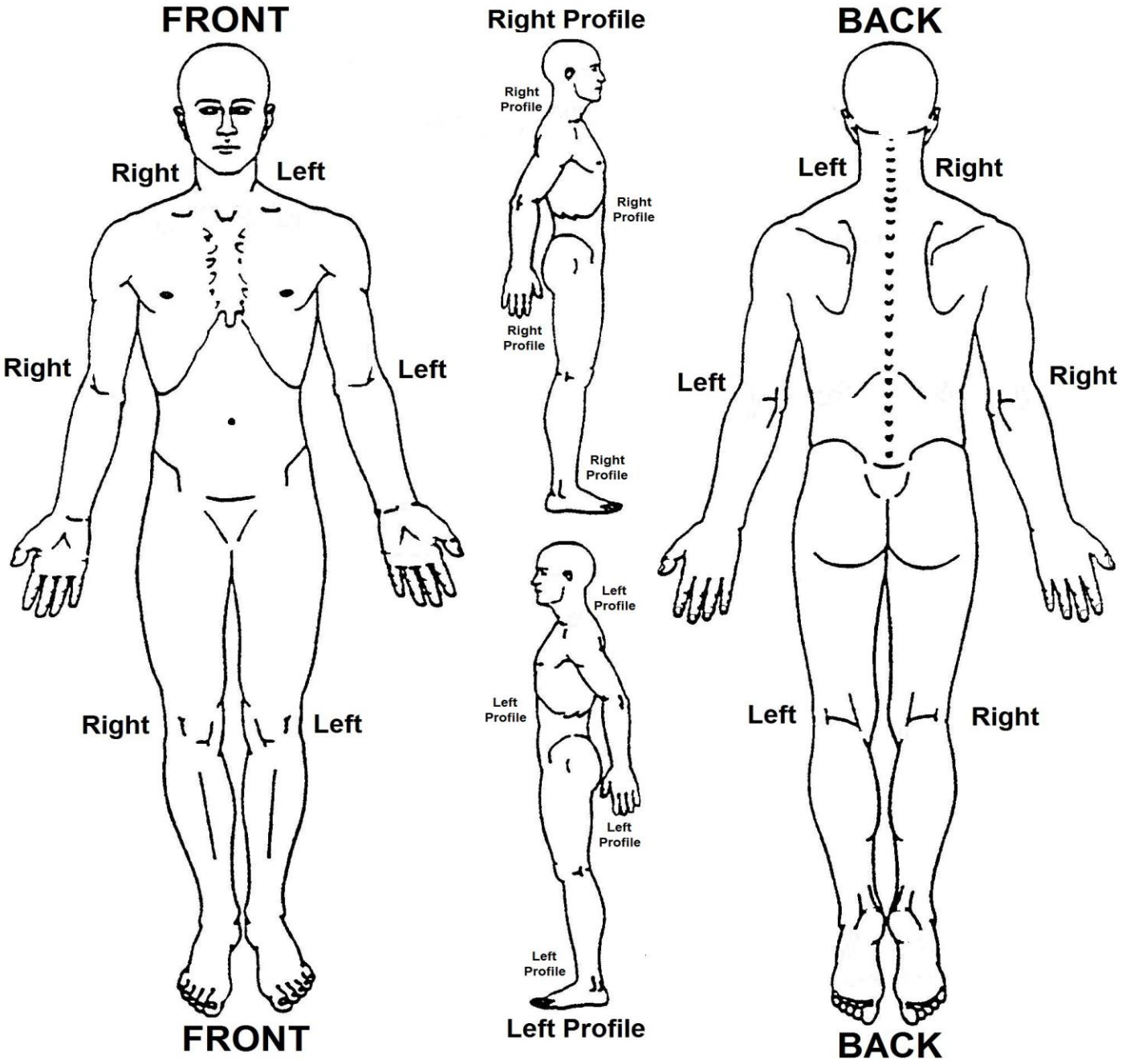
0 • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

Pain Diagram

Mark the areas on your body where you feel your symptoms. Include all affected areas. Use any of these symbols:

Ache ° ° ° ° ° ° ° ° ° °	**Burning** > > > > > >	**Cramping** ! ! ! ! ! ! ! !	**Hurting** # # # # # # # #
Jabbing Φ Φ Φ Φ	**Numbness** + + + +	**Pins & Needles** = = = =	**Pressure** ^ ^ ^ ^ ^ ^
Pulling ÷ ÷ ÷ ÷ ÷ ÷ ÷ ÷	**Sharp** ✓✓✓✓✓✓	**Shooting** ? ? ? ? ? ? ?	**Sore** $ $ $ $ $ $ $
Stabbing • • • • • • •	**Tearing** ~ ~ ~ ~ ~ ~	**Tender** * * * * * * * *	**Throbbing** / / / / / / / / /

Name your own sensation if different from above _____ (use this symbol) □ □ □ □ □ □ □



(name) _____ (date) _____ (page 2 of 5)

Skip This Page If You Do Not Have Secondary or Tertiary (Third) Symptoms

Where is your **SECONDARY** symptom? location: _____

How long ago did your **SECONDARY** symptom begin? _____

How did your **SECONDARY** symptom begin? (circle) **Gradually** **Suddenly**

Your **SECONDARY** symptom is: (circle any) **Constant** **Intermittent** **Worsening** **Improving** **Plateaued**

Your **SECONDARY** symptom feels like: (circle any) **ache** **burning** **cold** **crampy** **dull** **hot** **hurt** **itchy** **jabbing** **numbness** **pins & needles** **pressure** **pulling** **sharp** **shooting** **sore** **stabbing** **tearing** **tender** **throbbing**

Do you have **weakness?** **YES** **NO** (if yes, is weakness **Constant** or **Intermittent** or **Posture Dependent**?)

Circle the intensity of your **SECONDARY** symptom on the ten point pain scale:

(**Pain Intensity Scale:** ⓪ represents no pain and ⑩ represents the worst pain you can possibly imagine)

0 • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

Check mark ✓ how each activity below impacts your **SECONDARY** symptom:

	Aggravates	**No Change**	**Relieves**
While Sitting			
While Standing			
Moving from Sit to Stand			
Walking			
Lying on Stomach (prone)			
Lying on Back (supine)			
Lying on Left Side			
Lying on Right Side			
Pushing a Shopping Cart			
Everything			
Nothing			

Where is your **THIRD** symptom? location: _____

How long ago did your **THIRD** symptom begin? _____

How did your **THIRD** symptom begin? (circle) **Gradually** **Suddenly**

Your **THIRD** symptom is: (circle any) **Constant** **Intermittent** **Worsening** **Improving** **Plateaued**

Your **THIRD** symptom feels like: (circle any) **ache** **burning** **cold** **crampy** **dull** **hot** **hurt** **itchy** **jabbing** **numbness** **pins & needles** **pressure** **pulling** **sharp** **shooting** **sore** **stabbing** **tearing** **tender** **throbbing**

Do you have **weakness?** **YES** **NO** (if yes, is weakness **Constant** or **Intermittent** or **Posture Dependent**?)

Circle the intensity of your **THIRD** symptom on the ten point pain scale:

(**Pain Intensity Scale:** ⓪ represents no pain and ⑩ represents the worst pain you can possibly imagine)

0 • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

Check mark ✓ how each activity below impacts your **THIRD** symptom:

	Aggravates	**No Change**	**Relieves**
While Sitting			
While Standing			
Moving from Sit to Stand			
Walking			
Lying on Stomach (prone)			
Lying on Back (supine)			
Lying on Left Side			
Lying on Right Side			
Pushing a Shopping Cart			
Everything			
Nothing			

Circle any of the following diagnostic studies you have undergone for your current symptoms:

	Where (Facility / Location)	Date
Plain X-ray	_____	_____
CT Scan	_____	_____
MRI	_____	_____
Bone Scan	_____	_____
EMG	_____	_____
Discogram	_____	_____

Have you undergone any of the treatments listed below to try to resolve your symptoms? Check mark ✓ your responses.

		Permanently Helpful	Temporarily Helpful	Not Helpful	Made Me Worse	When?
Chiropractic Care	YES NO					
Acupuncture	YES NO					
Epidural Injections	YES NO					
Facet Joint Injections	YES NO					
Trigger Point Injections	YES NO					
PRP or Stem Cell Inject.	YES NO					
Other Injections: _____						
Aquatic Therapy	YES NO					
Physical Therapy	YES NO					
Independent Exercises	YES NO					
Traction	YES NO					
TENS Unit	YES NO					
Other Treatment: _____						

List all of the physicians and/or chiropractors you have consulted for your present condition _____

_____

REVIEW OF SYSTEMS ***Circle All That Apply Right Now***

Allergy & Immunology: list all medication allergies or intolerances & include the reaction to each drug: _____

_____ _____ _____ _____ _____ _____

X-ray dye allergy? **YES NO** Latex allergy? **YES NO** ChloraPrep (chlorhexidine) allergy? **YES NO** Gentamycin allergy? **YES NO**

Do you have an infection anywhere in your body currently? **YES NO** If yes what infection? _____

Are you currently taking antibiotic, antiviral or antifungal medications? **YES NO** If yes what is the stop date? _____

Musculoskeletal: **joint instability** **joint swelling** **joint stiffness** **muscle swelling** **TMJ syndrome**

Neurologic: **seizures** **tremor** **speech difficulty** **face droop** **chronic headache**

Psychiatric: **anxiety** **depression** **hallucinations** **addictions** **phobias**

Constitutional: **fevers** **chills** **night sweats** **unexplained weight loss** **can't fall asleep** **can't stay asleep**

Genitourinary: **painful urine** **blood in urine** **frequent urine** **stress urine incontinence** **total urine incontinence**

For Females Only: Are you, or could you be **pregnant?** **YES NO**

Gastrointestinal: **nausea** **vomiting** **diarrhea** **constipation** **bowel incontinence**

Cardiovascular: **short of breath while active** **chest pressure** **excessive sweating** **fainting** **leg swelling**

Respiratory: **short of breath at rest** **productive cough** **coughing blood** **wheezing** **sleep apnea**

Skin: **skin color change** **rash** **itching** **hair growth change** **nail growth change**

Endocrine: **excessive urine** **excessive thirst** **cold intolerance** **heat intolerance** **excessive hair growth**

Medications: Which medications are you taking **NOW** for your **current symptoms**? Circle one of these symbols to indicated how each medication works for you: very helpful ↑ partially helpful ≈ not helpful ↓ causes side effects Ø

①↑≈↓Ø_____ ②↑≈↓Ø_____ ③↑≈↓Ø_____ ④↑≈↓Ø_____
⑤↑≈↓Ø_____ ⑥↑≈↓Ø_____ ⑦↑≈↓Ø_____ ⑧↑≈↓Ø_____

Have you tried or are you currently taking? (circle any that apply) Tylenol ↑≈↓Ø acetaminophen ↑≈↓Ø ibuprofen ↑≈↓Ø
Advil ↑≈↓Ø Motrin ↑≈↓Ø Aleve ↑≈↓Ø Naproxen ↑≈↓Ø or any other over-the-counter (OTC) or prescription anti-inflammatory medications? (write in any others) ①↑≈↓Ø_____ ②↑≈↓Ø_____ ③↑≈↓Ø_____

In the **past 12 months** have you taken **steroid tablets** or received **steroid injections**? **YES** **NO** (circle any that apply)
Cortisone ↑≈↓Ø Prednisone ↑≈↓Ø Methylprednisolone ↑≈↓Ø Medrol Dose Pack ↑≈↓Ø Depomedrol ↑≈↓Ø Kenalog ↑≈↓Ø
Celestone ↑≈↓Ø other steroid ↑≈↓Ø_____
How many steroid treatments in the past 12 months? _____ When was the last steroid treatment? _____

Which medications have you taken in the **PAST** (but are no longer taking) for your **current symptoms**?

①↑≈↓Ø_____ ②↑≈↓Ø_____ ③↑≈↓Ø_____ ④↑≈↓Ø_____
⑤↑≈↓Ø_____ ⑥↑≈↓Ø_____ ⑦↑≈↓Ø_____ ⑧↑≈↓Ø_____

Which medications or supplements are you taking now for **other** medical conditions?

_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____

Past Medical History:

Circle any medical conditions that apply to you:

Osteoporosis(penia)	Diabetes (____ yrs.)	Pacemaker	Blood Vessel Disease	Emphysema
Stomach Ulcers	Kidney Disease	Coronary Artery Disease	Stroke or Blood Clots	Asthma
Gastric Reflux	High Cholesterol	Congestive Heart Failure	Neurological Disease	Depression
Thyroid Disease↓↑	Hepatitis	Atrial Fibrillation	Seizures	Anxiety
Skin Disorders	Liver Disease	High Blood Pressure	Fibromyalgia	Gout
Cancer (what kind) _____		Heart Attack	Arthritis or Rheumatoid	HIV / AIDS
		Drug or Alcohol Addiction	Other Conditions: _____	

Past Surgical History: Please list all previous surgeries:

[Surgery_____ Date_____] [Surgery_____ Date_____] [Surgery_____ Date_____]
[Surgery_____ Date_____] [Surgery_____ Date_____] [Surgery_____ Date_____]
[Surgery_____ Date_____] [Surgery_____ Date_____] [Surgery_____ Date_____]

Family History: List any medical conditions that exist in your blood relatives and identify their relationship to you:

_____ _____ _____ _____ _____ _____
_____ _____ _____ _____ _____ _____

Social History:

Are you currently (please circle): **Single** **Married** **Separated** **Divorced** **Widow / Widower** **Other**
If married, what is the age and health status of your spouse? Age:_____ Health Status: _____
Do you have children? **YES** **NO** How many:_____ Ages: _____
What was the last school grade you completed?_____ List other degrees: _____
Do you drink alcoholic beverages? **YES** **NO** which? (circle) **beer** **wine** **liquor** Drinks per day:_____
Do you use nicotine products? **YES** **NO** which? (circle) **cigarettes** (packs/day: ___) **smokeless** **vapor** **cigars** **pipe**

Occupational History: Are you retired? **NO** **YES** (If yes, when?) _____
Name of employer:_____ **part time** or **full time** How long: _____
Job Title:_____ Shift: **1st** **2nd** **3rd** Date you last worked: _____
Are you working with restrictions? **YES** **NO** If yes what are your restrictions? _____
Have you been laid off? **YES** **NO** If yes, is the layoff (circle): **Temporary** **Permanent** **Seasonal**
Are you on disability? **YES** **NO** If yes (circle) **Short Term** **Long Term** **Social Security** Other_____

(name) _____ (date) _____ Revised 04-12-2019