GERACI SPINE AND SPORTS MEDICINE

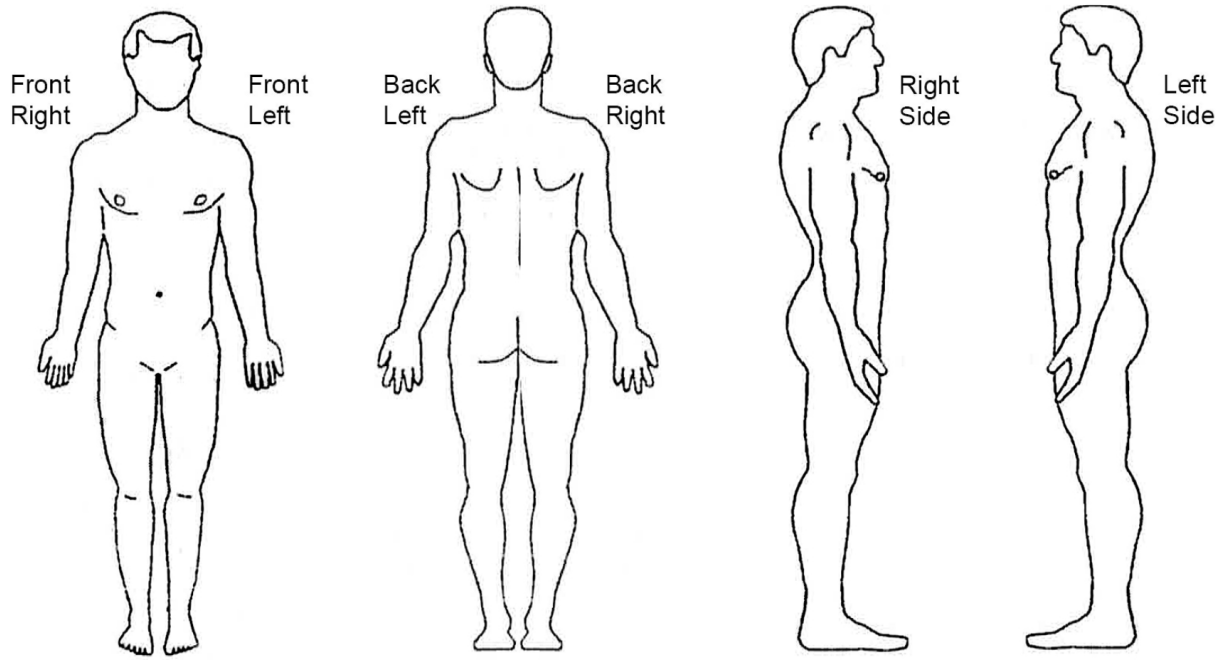
Patient Name:_____ DOB:_____

INITIAL HISTORY & PHYSICAL EXAM

☐ **Right Handed** ☐ **Left Handed** **Age:_____**

Pain Drawing

Instructions: Shade in these drawings according to where your symptoms are (if the right side of your neck hurts, shade in the drawing on the right side of the neck, etc.)



Symptom(s) Level: Please circle below the lowest and highest since your symptoms began

0 1 2 3 4 5 6 7 8 9 10

No Symptom(s) worst symptom(s) possible

Since the onset of your symptoms have they been:

Better Worse Same

Symptom(s) Quality: please circle below symptoms that apply

Sharp Dull Burning Pinching Numbness Tingling Choking Stabbing Other

Timing of Symptom(s): please circle

Constant Fleeting Intermittent Occasional

Doctors section: Do not write or initial your name

____I have reviewed the information and agree or have made changes

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Patient Name:_____ DOB:_____

Please list the **3 most important questions** you would like answered during today's visit:

1. _____

2. _____

3. _____

(Do Not Write in This Section, Begin With Question #1)

CC: _____

_____

_____

1. Date of injury or date symptoms began: _____/_____/_____

2. Briefly describe how the injury or symptoms began: _____

_____

_____

3. Please list other injuries associated with question #2: _____

4. Please list previous back, neck and/or joint problems: _____

5. Is this a:

_____ Work Related Injury

_____ Injury Related To A Motor Vehicle Accident

_____ Sports Related Injury

_____ Unrelated To Any Particular Incident

_____ Other _____

6. Are you currently able to work? ____ No ___ Yes Are you able to go to school ____ No ___ Yes

a. Occupation: _____ At time of injury: _____

b. _____ Regular Duty _____ Modified/Light Duty _____ Other: _____

c. Date Last Worked: _____/_____/_____

d. What was the longest amount of time you have missed work for any reason: _____

e. During your work day how many hours do you:

Sit _____ Stand _____ Walk _____

Lift _____ (10-20-30-40-50 lbs) (>50 lbs) Bending _____

circle lowest and highest

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7. Do you play any sports? ___ No ___ Yes ___ Modified ___ JV ___ Varsity ___ Other: _____

a. Name of your sport(s): _____

b. Position(s) that you play? _____

c. Have you missed any time from your sport(s)? _____

8. Do you take care of anyone with a disability in your home? ___ No ___ Yes

a. If yes, please explain: _____

9. Check which of the following activities change the nature of your symptom(s), if applicable

	Aggravates Pain	Relieves Pain		Aggravates Pain	Relieves Pain
Sitting	_____	_____	Side Bending	_____	_____
Standing	_____	_____	Twisting	_____	_____
Walking	_____	_____	Lying Down	_____	_____
Bending Forward	_____	_____	Other	_____	
Bending Backward	_____	_____		_____	
Rising From Sitting	_____	_____		_____	

10. What specific activities have you given up because of your symptoms)?

_____

11. List all physicians you have consulted for your present condition:

_____

12. Have you had any treatments) with: (please check ALL that apply):

_____ **PHYSICAL THERAPY:** Where: _____ Is it helping: ____ Yes ____ Not Responding

Frequency _____ On-Going: _____ _____ On Hold _____ Out of Insurance

a) Began _____/_____/_____ Ended _____/_____/_____ b) Did the treatment help? ____Yes ____No

c) Percent of Improvement 25 50 75 100

_____ **CHIROPRACTOR:** Where: _____ Is it helping: ____ Yes ____ Not Responding

Frequency _____ On-Going: _____ _____ On Hold _____ Out of Insurance

a) Began _____/_____/_____ Ended _____/_____/_____ b) Did the treatment help? ____Yes ____No

c) Percent of Improvement 25 50 75 100

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13. Have you had any of the following studies for your current symptoms?

___ X-Ray ___ MRI ___ CT ___ Bone Scan ___ Bone Density (DEXA) ___ Discogram

___ EMG (Muscle/Nerve) ___ Ultrasound ___ Other _____

a. Have you had any injection(s) for your symptom(s)? ___ No ___ Yes

If yes, please provide type and approximate year _____

If current, please give date _____/_____/_____

Did the injection help? ___ No ___ Yes

If yes, percent of improvement: 25 50 75 100

How long? _____

b. Have you ever had x-ray dye? ___ No ___ Yes

Are you allergic to x-ray dye? ___ No ___ Yes

If yes, circle one: Before 1990 After 1990 Name of Dye _____

Type of reaction: _____

c. Have you had spine surgery in the past? ___ No ___ Yes

If yes, please provide type and approximate year: _____

If current, please give date _____/_____/_____

Did the surgery help? ___ No ___ Yes

If yes, percent of improvement: 25 50 75 100

How did the improvement last? _____

14. **Review of Symptoms:** _____ All Negative

___ Change in ability to pass urine
___ Change in bowel movements
___ Difficulty breathing
___ Difficulty falling asleep
___ Difficulty staying asleep
___ Feeling tired in the morning
___ Numbness
___ Dizziness
___ Fainting
___ Fever
___ Headaches
___ Loss of consciousness
___ Night pain
___ Difficulty walking
___ Irregular heartbeat or palpitations
___ Rashes or blisters (other skin changes)
___ Swelling of toe or finger joints
___ Unexplained weight loss
___ Vision changes
___ Difficulty swallowing
___ Weakness

15. **Past Medical History:** _____ None

___ Angina
___ Anxiety
___ Arthritis
  ___ Rheumatoid
  ___ Osteo
  Please list joints affected
  _____
___ Breathing Problems:
  ___ Asthma
  ___ COPD
  ___ Chronic Bronchitis
  ___ Emphysema
___ Cancer
  Type/Location: _____
___ Circulation Disorder/PVD
___ Congestive Heart Failure
___ Coronary Artery Disease
___ Depression
___ Diabetes
___ Heart Attack
  Age(s) when heart attack happened _____
___ High Blood Pressure
___ High Cholesterol
___ Intestinal Disorder(s)
  (IBS, Stomach Ulcers, Ulcerative Colitis, Crohn's Disease)
___ Kidney Failure
___ Liver Disease
___ Neurologic Disorder
  Type _____
___ Osteoporosis/Osteopenia
___ Prostate Disorder: BPH
  Type: (ie, Prostatitis/Cancer/Other) _____
___ Reflux/GERD
___ Stomach Ulcers
___ Stroke
___ Thyroid Disorder
  __ Under Active __Over Active
  __ Hashimoto's. __ Other

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Please list any medical problems not listed on previous page: _____

_____

16. a. List all medications and supplements you are on NOW for your symptoms or **see attached list**:

_____

b. List all medications and supplements you have tried for you symptoms:

_____

c. List all other medications and supplements you are currently taking or **see attached list**:

_____

17. **Allergies to**:

Medications: _____

Food: _____

Environmental: _____

Seasonal: _____

18. **Past Surgical History:**

Please list all previous non-spinal surgeries:

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____
4. _____ Year _____
5. _____ Year _____
6. _____ Year _____

19. **Family Medical History:** Please circle all that apply

Mother:	Alive/Well/Deceased	List all medical problems: _____
	Age: _____	_____
Father:	Alive/Well/Deceased	List all medical problems: _____
	Age: _____	_____
Children:	Alive/Well/Deceased	List all medical problems: _____
	Age: _____	_____
Brother(s):	Alive/Well/Deceased	List all medical problems: _____
	Age: _____	_____
Sister(s):	Alive/Well/Deceased	List all medical problems: _____
	Age: _____	_____

List any other medical problems in family members other than above: (ie, grandparents, aunts, uncles, cousins)

_____

_____

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20. **Personal and Social History:**

a. Do you smoke? ___ No ___ Yes ____ Packs per day X ____ years

b. If no, did you smoke previously? ____ Packs per day X ____ years

c. If you did quit, when did you quit: _____ If this year, give a date: _____/_____/_____

If not what year? _____

d. Do you drink alcoholic beverages? ___ No ___ Yes

How much per week _____ Beer / wine / other: _____

e. If no, did you drink previously? ___ No ___ Yes

How much per week _____

f. How many years did you drink? _____ If you quit, when did you quit? _____

g. Do you drink caffeinated beverages? (coffee, tea, soda pop) ___ No ___ Yes

How many cups or glasses per day _____

h. Do you have a present drug addiction? ___ No ___ Yes

If yes, please list to **what**: _____

i. Did you ever have a drug addiction? ___ No ___ Yes

If yes, please explain: _____

j. Do you exercise? ___ No ___ Yes

k. Are you currently: Single Married Divorced Separated Widowed

l. Current living situation: Alone Children Partner/Spouse Friend Parent Other: _____

m. Education level: (circle the highest level that you have completed)

Grade School High School/GED College Post College Other: _____

n. If your symptoms were better, what two physical activities would you like to do better or return to doing?

1. _____
2. _____

o. Currently (or before symptoms began), what regular exercises were you doing (examples: walking, running, weight training)?

1. _____
2. _____

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