GERACI SPINE AND SPORTS MEDICINE

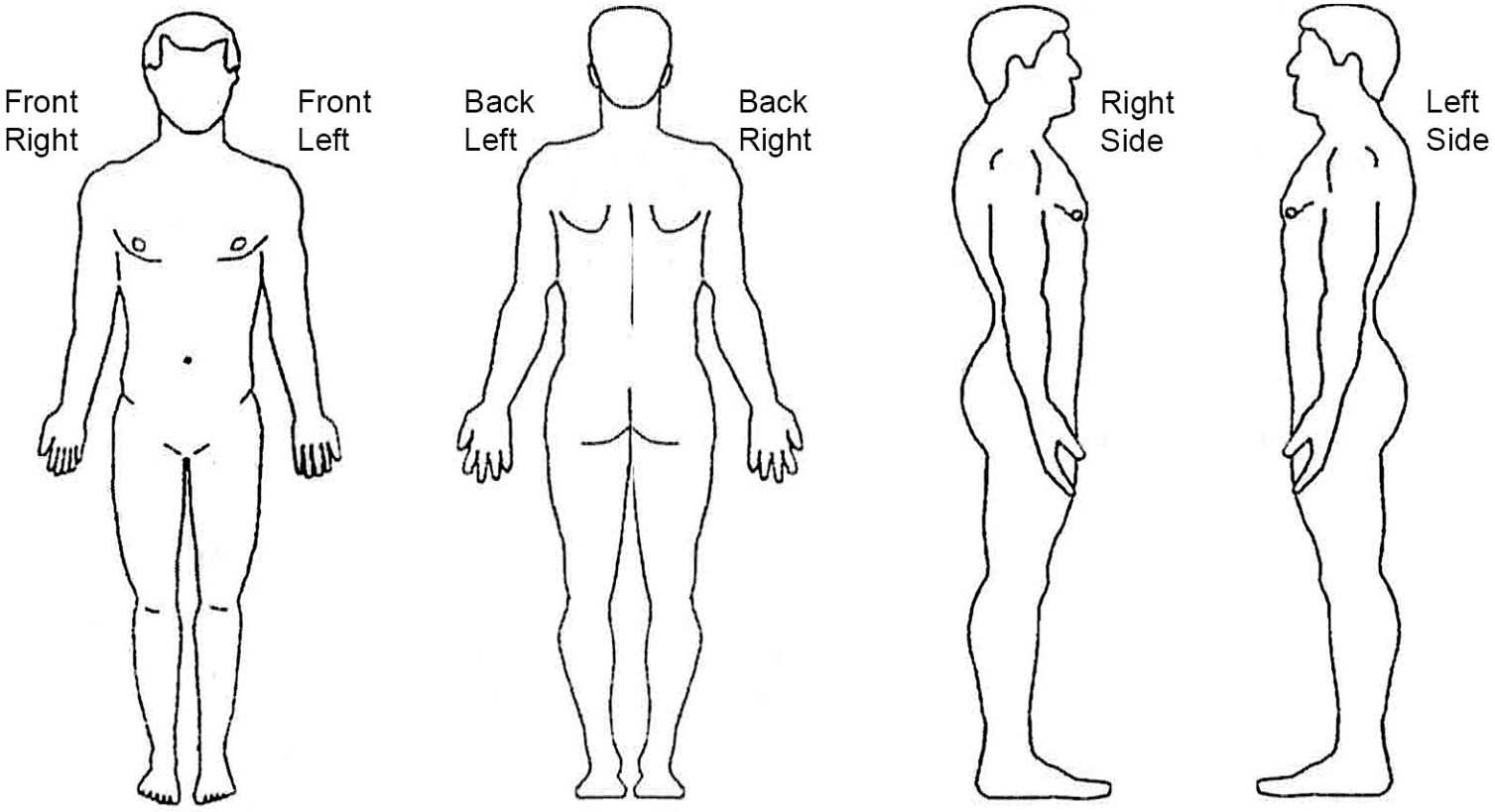
Motion For Life INITIAL HISTORY & PHYSICAL EXAM

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ ☐ Right Handed ☐ Left Handed

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.)



Sympton(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

PATIENT NAME: _____ DOB: _____ Page 2

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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PATIENT NAME: _____ DOB: _____

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: _____

If not Workers' Compensation or No-Fault related proceed to question #10

9. Have you or will you file a Workers' Compensation or No-Fault insurance claim? (if you do file a case after this visit, you will need to send a written explanation of how the injury occurred to our office.)

a. ___ No _____ Yes _____ WC _____NF Date of Injury: ____/____/____

b. At any point in time have you had a previous Workers' Compensation or No-Fault Claim?
___ No _____ Yes _____ WC _____NF Date of Injury: ____/____/____

c. Where were your symptoms after the injury? _____

d. What was your occupation at the time of the injury? _____

10. 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(s)	_____	_____
Bending Backward	_____	_____	_____	_____	_____
Rising from Sitting	_____	_____	_____	_____	_____

11. What specific activities have you given up because of your symptom(s)?

_____

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

_____

13. Have you had any treatment(s) 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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PATIENT NAME: _____ DOB: _____ Page 4

14. 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 _____

c. Have you had any injection(s) for your symptom(s)? _____No _____ Yes
If yes, please provide type and approximate year _____
If current year please give date ____/ /_____

Did the injection help? _____ No _____Yes
If yes, percent of improvement: 25 50 75 100
How Long? _____

d. Have you ever had x-ray dye? _____ No _____ Yes
Are you allergic to x-ray dye? _____ No _____ Yes
1. If yes, circle one: Before 1990 After 1990 Name of Dye_____
2. Type of reaction: _____

e. Have you had spine surgery in the past? _____ No _____ Yes
b. If yes, please provide type and approximate year: _____
If current year please give date: _____/ _____/_____
c. Did the surgery help? _____ No _____ Yes
If yes, percent of improvement 25 50 75 100
How long did the improvement last? _____

15. **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

16. **Past Medical History**: _____None

_____ Angina
_____ Anxiety
_____ Arthritis
_____ Rheumatoid
_____ Osteo
Please list joint(s) affected
_____
_____Breathing Problems:
_____Asthma
_____ COPD
_____ Chronic Bronchitis
_____ Emphysema
_____ Cancer ____Age
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)

Doctors section: Do not write or initial your name
_____ I have reviewed the information and agree or have made changes

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

_____

17. 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:** _____

_____

18. **Allergies to:**

Medications: _____

Food: _____

Environmental: _____

Seasonal: _____

19. **Past Surgical History:**

Please List all previous non-spinal surgeries:

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

20. **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) _____

_____

Doctors section: Do not write or initial your name

_____ I have reviewed the information and agree or have made changes

21. Personal and Social History:

a. Do you smoke? _____Yes _____ No _____ Packs per day X _____ years

b. If no, did you smoke previously: _____ Packs per day _____ years.

c. If you did quit, when did you quit: _____ This year, give a date: ____/____/____ if not what year? _____

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

   a. How much per week _____ Beer / Wine / Other: _____

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

   a. 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) _____Yes _____ No

   a. How many cups or glasses per day: _____

h. Do you have a present drug addiction? _____ Yes _____ No If yes, please list to What? __ _____

i. Did you ever have a drug addiction? _____ Yes _____ No If yes, please explain: _____ _____

j. Do you exercise? _____ Yes _____ No

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. _____

Doctors section: Do not write or initial your name

_____ I have reviewed the information and agree or have made changes