SOUTHWEST SCOLIOSIS INSTITUTE

PATIENT NAME: _____ DATE: _____

ADULT PATIENT MEDICAL HISTORY

The completion of this form is important to ensure the quality and accuracy of your care. This information is personal and confidential.

IS THIS A WORK-RELATED INCIDENT: YES ☐ NO ☐ IF YES, DO YOU HAVE OR PLAN TO HAVE A WORK COMP CLAIM; YES ☐ NO ☐
IS THIS RELATED TO A MOTOR VEHICLE ACCIDENT: YES ☐ NO ☐ IF YES, STATE & DATE OF ACCIDENT: _____

CHIEF COMPLAINT: _____

DURATION: _____ DATE INITIAL DIAGNOSIS GIVEN: _____

MY PAIN IS: Please fark all that apply

☐ Aching	☐ Sharp	☐ Penetrating	☐ Throbbing	☐ Tender	☐ Electric
☐ Nagging	☐ Shooting	☐ Burning	☐ Stabbing	☐ Constant	☐ Numb
☐ Exhausting	☐ Miserable	☐ Gnawing	☐ Tiring	☐ Unbearable	

MY PAIN IS WORSE WITH:

☐ Walking ☐ Sitting ☐ Bending ☐ Working ☐ Physical Activity

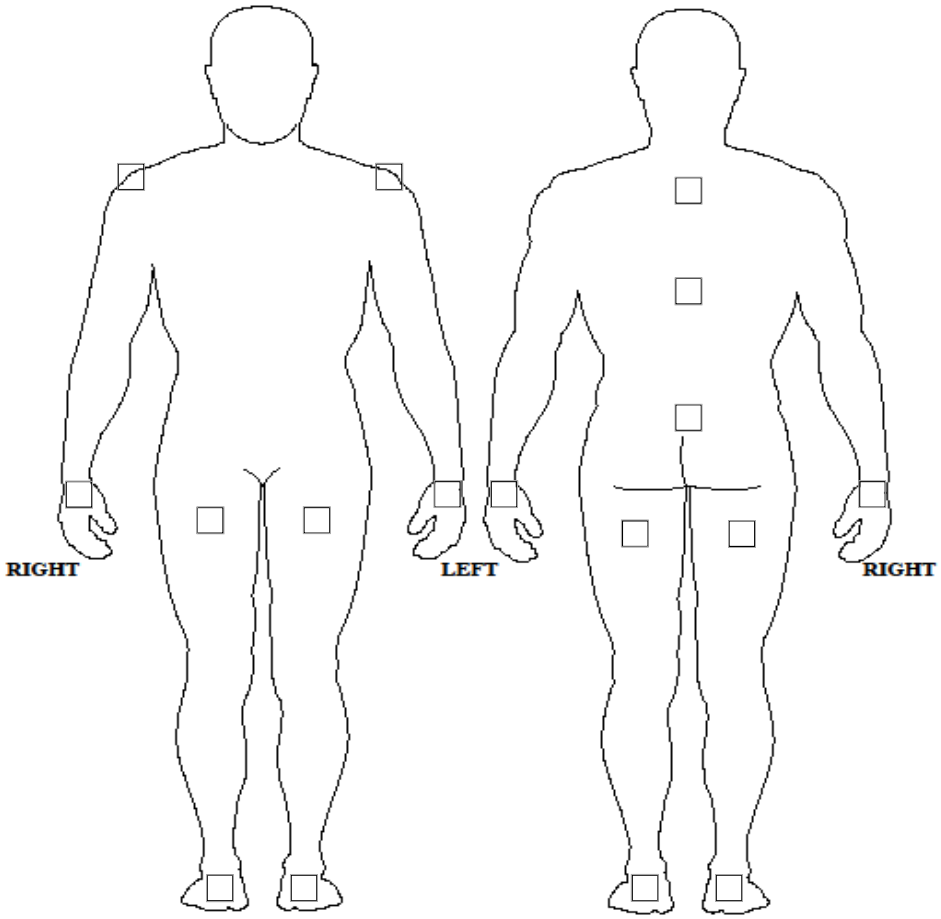
My Pain is made better by: _____

Please mark the number that best describes your pain level today (0 being none and 10 being extreme)

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

PAIN DRAWING

Please mark below on the pain drawing where/ if you experience pain (XXX), tingling (000) or numbness (III)



SOUTHWEST SCOLIOSIS INSTITUTE

PATIENT NAME: _____ DATE: _____

MEDICATION: Please list name, dose, times per day and prescribing physician. Also include all over the counter/ supplemental medications.

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES: Please be sure to list any life-threatening allergies including XRAY dye, Shellfish, Iodine, Adhesive tape, antibiotics or metals and what type of reaction occurs i.e. nausea, rash, etc.

- _____
- _____

PAST CONSERVATIVE TREATMENT HISTORY:

- YES / NO Have you tried bracing? If yes, what type, when and for how long:_____
- YES / NO Have you tried physical therapy or a core strengthening program such as Pilates?
  If yes, when was your last treatment session: _____
- YES / NO Have you tried injections? If yes, what types of injections/levels:
  Facet: _____ Date: _____ / ESI: _____ Date: _____ / Rhizotomies: _____ Date: _____
  Who performed the injections? _____ Phone: _____
- YES / NO Have you tried nonsteroidal anti-inflammatories (NSAIDS)
  If yes, name(s) of medication: _____ If you can't take anti-inflammatories, reason why:
  _____
- OTHER: (Please mark all that apply) ☐ Chiropractic Care ☐ Heat ☐ Ice ☐ Massage ☐ Home exercise program
- Other: _____

MEDICAL PROBLEMS: Examples would be asthma, high blood pressure, cancer, high cholesterol, etc. Please include any hospitalizations

_____ _____ _____

_____ _____ _____

_____ _____ _____

SURGERIES:

YEAR	PROCEDURE	SURGEON	LOCATION/HOSPITAL

ANESTHESIA COMPLICATIONS: Have you had any complications or reactions with anesthesia or anything associated with surgery? If yes, please explain.

- _____

FAMILY HISTORY: (This pertains to member of your family (blood related) i.e.: mother, father, maternal/paternal grandparents)

YES / NO Anesthesia Problems _____
YES / NO Bleeding Problems _____
YES / NO Cancer _____
YES / NO Diabetes _____
YES / NO Heart Attack-Male under 55 _____
YES / NO Heart Attack-Female under 65 _____
YES / NO Osteoporosis _____
YES / NO Rheumatoid Arthritis _____
YES / NO Heart Attack _____
YES / NO Heart Disease _____
YES / NO Hypertension (high blood pressure) _____
YES / NO Blood Clots _____
YES / NO Tuberculosis _____
YES / NO Scoliosis _____
YES / NO Stroke _____

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PATIENT NAME: _____ DATE: _____

SOCIAL HISTORY:

- Are you retired? YES ☐ NO ☐ Are you married? YES ☐ NO ☐ Are you on disability? YES ☐ NO ☐
- OCCUPATION: _____
- YES/ NO Do you have any children? If yes, how many children and their ages: _____
- YES / NO Do you currently smoke cigarettes, e-cigarettes, or cigars, dip or chew tobacco, or use any other form of nicotine product? If yes, how many packs per day and for how many years: _____
  If no, have you ever used or when did you quit: _____
- YES/ NO Do you drink alcohol? If yes, do you drink often, socially or rarely: _____ or
  How many drinks do you have in a day, week or month? _____

REVIEW OF PERSONAL HISTORY/SYSTEMS: (This pertains only to you, the patient) Mark all that apply

☐ Fever/Chills	☐ Wheezing	☐ Itching
☐ Fatigue	☐ Heartburn	☐ Numbness
☐ Sleep Problems	☐ Constipation	☐ Tingling
☐ Blurry Vision	☐ Nausea	☐ Headaches
☐ Double Vision	☐ Vomiting	☐ Stroke
☐ Decreased Hearing	☐ Diarrhea	☐ Loss of Balance
☐ Sore Throat	☐ Pain on Urination	☐ History of Seizures
☐ Ears Ringing	☐ Incontinence	☐ Anxiety
☐ Trouble swallowing	☐ Increased Frequency	☐ Depression
☐ Chest Pain	☐ Leg Pain	☐ Excessive Worry
☐ Fainting	☐ Arm Pain	☐ Memory Loss
☐ Hypertension	☐ Neck Pain	☐ Weight Change
☐ Heart Failure	☐ Back Pain	☐ Thirsty All the Time
☐ Lung/Pulmonary Issues	☐ Joint Swelling	☐ Easy Bruising
☐ Stress Test	☐ Arthritis	☐ Bleeding
☐ Heart Catheterization	☐ Cramps	☐ Frequent Infections
☐ Shortness of Breath	☐ Weakness	☐ Enlarged Lymph Nodes
☐ Cough	☐ Rash	☐ Hepatitis
☐ Asthma		

ADDITIONAL COMMENTS: Please include any important information that was not covered in the above section that you feel will be important or pertinent to your care:

_____

_____

All information given is trueand correct to the best of my knowledge.

_____ _____

Type name of person completing forms Date

_____ _____

Name of person completing form if other than patient Relation to Patient

SUBMIT