Back On Track Physical Medicine Patient History Form

Today's Date:		Nar	me:					_ DOB:			A	.ge	
Address:					City/Sta	ate/Zip							
Phone:			Email	•						Sex □	M 🗆	F	
SS#:				Marital Status:	¬S	D	¬W	Snouse	Name				
				Marital Otatas. I	_								
When did your pain begin?					CI	RCLE I	NUMBE	ER OF SE	VERITY	(0=No Pa	in 10=	Sever	e Pain) 9 10
When did your pain begin? How did your pain begin?		 ason □P	Rendina r	l ifting □Fall						4 5			9 10
				□Other									
Have you had similar episo	de befo	re? □ No	o □Yes	When	Si	houlde	Pain	0 1	2 3	4 5 4 5	6 7	8	9 10
What have you been told is	wrong?	?			El	bow Pa	ain	0 1	2 3	4 5	6 7	8	9 10
Doctors seen for this condit	tion?				W	rist Pa	n	0 1	2 3	4 5	6 7	8	9 10
Prior tests for your pain:					HI Kı	ip Pain	in	0 1	2 3	4 5 4 5 4 5 4 5 4 5 4 5	6 7	8	9 10
□X-Ray					Ar	nkle Pa	in	0 1	2 3	4 5	6 7	8	9 10
□MRI					,			•	_ 0	. 0	•	Ū	0 .0
□CT					Ple	ase ma	rk are	a(s) of na	in with t	he appro	oriate s	vmbc	ıls:
□Lab										ing Ach		tabbir	
Other						NN		PP	BE	•	•	SS	'9
								• •		, ,,,		,,	
Prior treatment for your c	urrent r	<u>problem</u>	:					_		_	-	_	1
□Ice/Heat □Aleve □Tyl						(-	3	0		(*)	87)	l
□ Pain Medication			scle Relax	er		13	Ž.	215		100	X	1	l
Has your pain: □Improved	□vvor	senea	□Not cna	ngea		12	7	17 6	1 1	11.11	60	1	l
Is your pain: □Constant	□Com	nes and (goes			15	1	12/20/20/h	4 4	MY.Y	1	11	l
How does the following a	ffect vo	our pain	?			10	1	1/4/1	11	11/10	1	18	l
	Worse	Better	No Char	nge		υň	1 %	14	P. 20	1 1 4	2	J.M	l
Cough/Sneeze						1	1	14/4		1.11.7	1.		l
Sitting						1	7	(A)		(iVi)	1)	l
Sit to Stand						1 \	1	111		\W/	- 1		l
Bending Forward						Į.	5			W	~	5	l
5 5								40					ı
Lifting													
Bending Backward													
Standing							E	OR PR	OVIDI	ER USI	E ON	LY	
Walking													
Going Up Stairs Going Down Stairs													
Lying on Stomach Looking Down													
Looking Up													
Turning Head													
ruming ricau	Ш	Ш			<u> </u>								
Family Medical History:	∃Heart o	disease	□Cancer	⊓I upus									
□Diabetes □Abnormal Ble													
□ Arthritis □ Drug Allergies	s □Ŏt ^l	her			-								
Living Mother □Y □N; Died	d at age	;	of										
Living Father □Y □N; Die													
					_								
Current Work Status													
Employer					_								
Position													
Off Work? □Y □N Dates	s off wor	ſ k :											$\overline{}$
Lifeetule Habit/s\:					<u> </u>								
<u>Lifestyle Habit(s):</u> □Tobacco(# per day	/) □ QI,	een	(hour	s ner day)									
□Alcohol(# per day	,, ⊔Ca	aneme De	everages _	(# per day)									
Do you exercise regularly?	пУ⊓	N											
Has your condition prevente			na exercisa	2? □Y □N	<u> </u>								
rias your condition prevent	ou you i	TOTTI UUII	ig cacidist	,. L.I. L.IN									

Name:	DOB:	Date:
Past Medical History	- Kidaaa Diaaaa	
	□Kidney Disease □Thyroid Disease	FOR PROVIDER USE ONLY
	□ Triyroid Disease □Tuberculosis	
	□ High Blood Pressure	
	□ Joint Replacement	
□ Blood Thinners □ Depression/Anxio	ety	
Are you pregnant? □Y □N How many mor	nths?	
Surgeries/Hospitalizations:		
1	Year:	
2.		
3.		
	-	
Injuries/Fractures/Dislocations:		
1.		
2.		
3	Year:	
List all medications you are currently taking		
Name of Medication Dosage	Date Started	
1		
•		
Drug/Food Allergies: □N □Y:		
Review of Systems: (Please check all that a	pply):	
□ Fever □ Night Sweats □ Unexplained we	ight loss	
□ Abrupt change in vision □ Abrupt change in	_	
□ Difficulty swallowing □ Sore throat □ Che		
□ Poor circulation □ Cough □ Difficulty brea □ Nausea □ Vomiting □ Bleeding □ Diarr		
□ Pain/swollen joints □ Rash □ Dizziness		
□ Muscle Weakness □ Hot flashes □ Bruise		
□Allergies to pollen, etc □Burning on urination		
□Loss of bladder/bowel control □Urinary tra		
□Respiratory □Skin □Immune system dy		
$\ \Box \mbox{Depression} \Box \mbox{Anxiety} \Box \mbox{Difficulty sleepin}$		
□Other		
5		
Emergency Contact:		
NameRelationship		
Phone:		
Health Insurance (Responsible Party) Inform	nation:	
Company Name:Policy/ID Number:		
Group Number:		
Policyholder Name:		
Relationship to Insured:		
Do you have any Secondary Insurance: □Y		
If yes, Company Name:		
Policy/ID Number:		
Who may we thank for your referral?		
who may we mank for your relenal!		