SOUTHWEST HEALTH SYSTEM

Please PRINT and fill out completely.

Date: _____/_____/_____
Name: _____ DOB:_____ Age:_____
Height _____ft. _____in. Weight_____lbs Sex:_____ Are you or could you be pregnant?_____
Your Occupation:_____ Employer:_____
Who referred you to this office? O Dr._____ O PA/NP _____
O Family/Friend _____ O Physical Therapist _____
O Other _____

HISTORY OF CARE

Who is your primary care physician? _____ Location: _____
Address: _____ Phone: _____
Please list any other doctors, clinics, or hospitals you have seen for your current spinal problems:

Name:	*City:*	*Date of First Visit:*	*Currently Continuing?:*

HISTORY OF CURRENT SPINAL PROBLEMS

List your chief complaints or main problems with the most severe first:

1. _____
2. _____
3. _____

Describe all details of any accident, incident or the way these problems began:
_____
_____
_____
_____
Is there current imaging available (i.e. MRI, CT) regarding this current spinal condition? _____
If so, at what facility was this performed? _____
Please bring a copy (CD or films) of your imaging to your appointment.

CURRENT SYMPTOMS

What time of day is your pain at its worst? O Morning O Afternoon O Evening O Night O N/A
Does the pain wake you up at night? O Yes O No
In the past six months have you experienced: O Fever O Weight Loss _____lbs
O Chills O Night Sweats
How would you describe your pain? O Constant O Constant, but worse with activity
O Intermittent (comes and goes)
O Intermittent, but worse with activity
Do you have full control of your bladder? O Yes O No
Do you have full control of your bowels? O Yes O No

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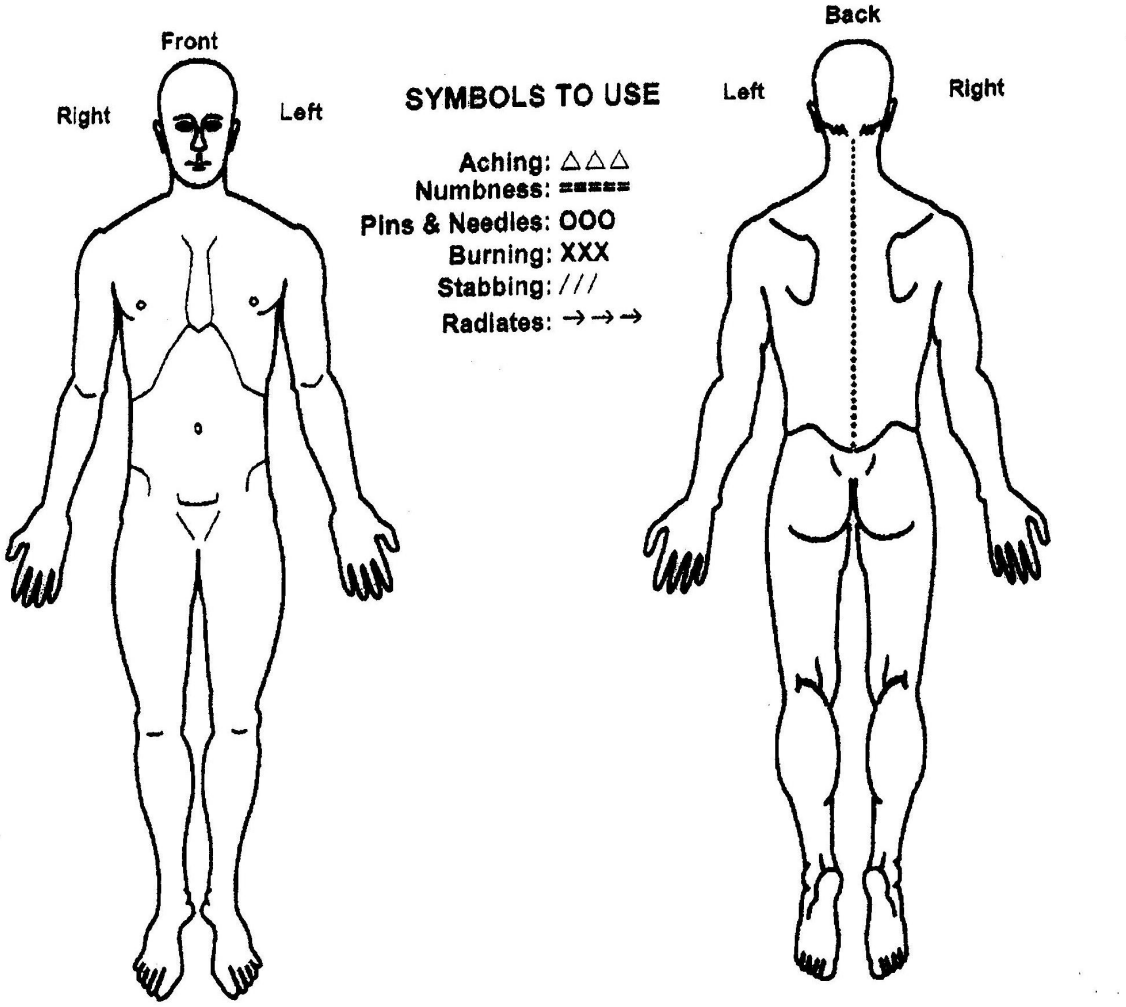
PATIENT PAIN DRAWING

Please mark the areas on your body where you feel the pain and/or sensations described below, using the appropriate symbol as indicated. Mark the areas where your pain radiates, including all affected areas.



Mark where any symptoms (pain, numbness, weakness, etc) exist on average (most of the time) and at their worst.

Current pain:

	None										Unbearable
Average	0	1	2	3	4	5	6	7	8	9	10
Worst	0	1	2	3	4	5	6	7	8	9	10

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1311 N. Mildred Road • Cortez, CO 81321
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MEDICAL HISTORY

Check if you are being treated for or have been diagnosed with:

	When?		When?
O High Blood Pressure	_____	O Osteoporosis	_____
O Diabetes	_____	O Kidney Disease/Problem	_____
O Liver Disease	_____	O Seizures	_____
O Heart Disease or Attack	_____	O Arthritis	_____
O Stroke	_____	O Thyroid	_____
O Cancer	_____	O Tuberculosis	_____
O High Cholesterol	_____	O Psoriasis	_____
O Ulcer Disease	_____	O Polio	_____
O Gastritis	_____	O Rheumatic Fever	_____
O Reflux Disease (GERD)	_____	O Gout	_____
O Asthma	_____	O Herpes Simplex	_____
O Depression	_____	O Bipolar Disease	_____
O Other Psychiatric	_____	O Pacemaker	_____

Have you ever had a history of blood clots or pulmonary embolus? O Yes O No

SURGERIES

Please list all ***spine*** surgeries you have had in the past:

Type of Surgery: *Date:* *Surgeon:*

_____
_____
_____
_____

Please list all ***other*** surgeries you have had in the past:

Type of Surgery: *Date:* *Surgeon:*

_____
_____
_____
_____

MEDICATIONS

Please list ALL medications you are **currently** taking, including prescription and over the counter:

Medication: *Dosage :* *Frequency: (how many pills in 24 hours)*

_____
_____
_____
_____

ALLERGIES

Please list any ***allergies or adverse reactions*** you have to medications:

Medication: *What Happened?:*

_____
_____
_____
_____

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FAMILY HISTORY

Is your father alive? O Yes O No IF YES, age and any major medical problems? _____
IF NO, age at time of death? _____ What major medical problems did he have? _____
Is your mother alive? O Yes O No IF YES, age and any major medical problems? _____
IF NO, age at time of death? _____ What major medical problems did she have? _____
Any siblings? O Yes O No How many? _____

SOCIAL HISTORY

Marital Status: O Married O Single O Divorced O Widowed O Living with other
Do you have children? O Yes O No Ages: _____
Education level achieved: O Grade School O Jr. High O High School O College O Post Graduate
DO you currently smoke cigarettes? O Yes O No Number of Years Smoked: _____ **FOR DR. USE:** P YRS _____
Packs per Day: (please choose the closest) O < ½ O ½ O 1 O 2 O >2
DID you smoke cigarettes in the past? O Yes O No Number of Years Smoked: _____ Quit Date: _____
Packs per Day: (please choose the closest) O < ½ O ½ O 1 O 2 O >2
Do you use any other tobacco products? O Yes O No What kind? _____ Quantity? _____
Do you use recreational drugs? O Yes O No What kind? _____
Do you drink alcohol? O Yes O No Drinks per Day _____ Drinks per Week _____
DO YOU OR HAVE YOU HAD an unhealthy relationship with alcohol? O Yes O No
Type of alcohol consumption: O Beer O Wine O Mixed Drinks

WORK HISTORY

Are you currently: O employed O unemployed O retired O on sick leave O on disability O stay at home parent
Has your job changed since your symptoms started? O Yes O No O Not working
If you are at a different job or not working, did your symptoms play a role in your job change or decision not to work? O Yes O No
If you are working, are you on: O Normal duties O Light duties
If you are on light duty, did your symptoms play a role? O Yes O No
Are you applying for disability? O Yes O No
Please describe your job: _____

WORKER'S COMPENSATION HISTORY

IS THIS A WORKERS COMPENSATION CASE? O Yes O No
Have you had any PRIOR workers compensation injuries? O Yes O No If yes, how many? _____
Please list any prior workers compensation cases/injuries:

Date: *Area Injured:* *Time Off Work:* *Who Treated You?:*

_____
_____
_____

Were you at work when your symptoms began? O Yes O No
Did you have a specific accident or injury while at work to cause your symptoms? O Yes O No
What is the company name? _____
Prior to your WC injury, how long had you been employed by that company? _____
Do you currently have an attorney for this episode? O Yes O No

SOUTHWEST HEALTH SYSTEM

CAR ACCIDENTS

WERE YOUR SYMPTOMS CAUSED BY A CAR ACCIDENT? O Yes O No
Have you had any PRIOR car accidents? O Yes O No If yes, how many? _____
Please list: *Date:* *Area Injured:* *Time Off Work:* *Who Treated You?:*

_____

_____

_____

Do you currently have an attorney for this episode? O Yes O No

REVIEW OF SYMPTOMS

Check Yes or No in the following areas. If "Yes," please describe:

1. CONSTITUTIONAL
   - A. Recent Weight Change? O Yes O No _____
   - B. Change or loss of appetite? O Yes O No _____
   - C. Fevers? O Yes O No _____
   - D. Chills? O Yes O No _____
   - E. Night Sweats? O Yes O No _____
   - F. Weakness/Fatigue? O Yes O No _____

2. EYES
   - A. Vision change? O Yes O No _____
   - B. Glasses/contacts? O Yes O No _____
   - C. Glaucoma? O Yes O No _____
   - D. Eye infections (iritis)? O Yes O No _____
   - E. Loss of Vision? O Yes O No _____

3. EARS, NOSE AND THROAT
   - A. Decrease or loss of hearing? O Yes O No _____
   - B. Earache or infection? O Yes O No _____
   - C. Tinnitus (ringing in ear)? O Yes O No _____
   - D. Nasal stuffiness/discharge? O Yes O No _____
   - E. Nosebleeds? O Yes O No _____
   - F. Sore throat? O Yes O No _____
   - G. Hoarseness? O Yes O No _____
   - H. Dental problems? O Yes O No _____
   - I. Dentures? O Yes O No _____
   - J. Difficulty swallowing? O Yes O No _____

4. CARDIOVASCULAR
   - A. Chest pain? O Yes O No _____
   - B. Shortness of breath? O Yes O No _____
   - C. Palpitations? O Yes O No _____
   - D. Swelling in the legs? O Yes O No _____
   - F. Pacemaker? O Yes O No
   - E. PLEASE LIST MOST RECENT HEART TESTS WITH NAME OF FACILITY, DATE, AND CONTACT PHONE NUMBER

     _____

SOUTHWEST HEALTH SYSTEM

5. RESPIRATORY
- A. Cough? O Yes O No _____
- B. Wheezing/asthma? O Yes O No _____
- C. Pneumonia or bronchitis? O Yes O No _____
- D. Shortness of breath? O Yes O No _____

6. GASTROINTESTINAL
- A. Abdominal pain? O Yes O No _____
- B. Nausea or vomiting? O Yes O No _____
- C. Constipation? O Yes O No _____
- D. Diarrhea? O Yes O No _____
- E. Heartburn/acid reflux? O Yes O No _____
- F. Rectal bleeding or black, tarry stools? O Yes O No _____

7. GENITOURINARY
- A. Increase frequency of urination? O Yes O No _____
- B. Pain/burning when you urinate? O Yes O No _____
- C. Frequent infection of urine? O Yes O No _____
- D. Incontinence (loss of control)? O Yes O No _____
- E. Reduced force of urination? O Yes O No _____

8. MUSCOLOSKELETAL
- A. Muscle aches? O Yes O No _____
- B. Joint pains/stiffness (arthritis)? O Yes O No _____
- C. Swelling of joints? O Yes O No _____

9. SKIN
- A. Rash? O Yes O No _____
- B. Lumps or sores? O Yes O No _____
- C. Changes in hair or nails? O Yes O No _____
- D. Dryness? O Yes O No _____
- E. Ulcers? O Yes O No _____
- F. Abnormal scars? O Yes O No _____

10. NEUROLOGICAL
- A. Headaches? O Yes O No _____
- B. Fainting/blackouts? O Yes O No _____
- C. Tremors/involuntary movements? O Yes O No _____
- D. Numbness, tingling? O Yes O No _____
- E. Dizziness? O Yes O No _____
- F. Muscle weakness? O Yes O No _____

11. PSYCHIATRIC
- A. Depression? O Yes O No _____
- B. Mood swings? O Yes O No _____
- C. Anger? O Yes O No _____
- D. Nervousness/anxiety O Yes O No _____

12. ENDOCRINE
- A. Excessive thirst or hunger? O Yes O No _____
- B. Hot/cold intolerance? O Yes O No _____
- C. Hot flashes? O Yes O No _____

13. HEMATOLOGICAL
- A. Easy bruising or bleeding? O Yes O No _____
- B. Past blood transfusions? O Yes O No _____

Patient Signature: _____ Date: _____

Additional comments:

_____

_____

_____

Physician Signature: _____ Date: _____

SOUTHWEST HEALTH SYSTEM

FOR PHYSICIAN USE ONLY

Ht. _____ Wt. _____ RH. _____ LH. _____

A. Inspection:
Scoliosis
Kyphosis
Gibbus
Skin-café aulait
Scars

B. Posture:
Forward Head
Forward Shoulders
Lumbar Lordosis
Abd. Protrusion Pelvic Shift
Pelvic Obliquity

C. Palpation:
Masses
Drop-offs
Spasms
Facet Tenderness
Tender/Trigger Points

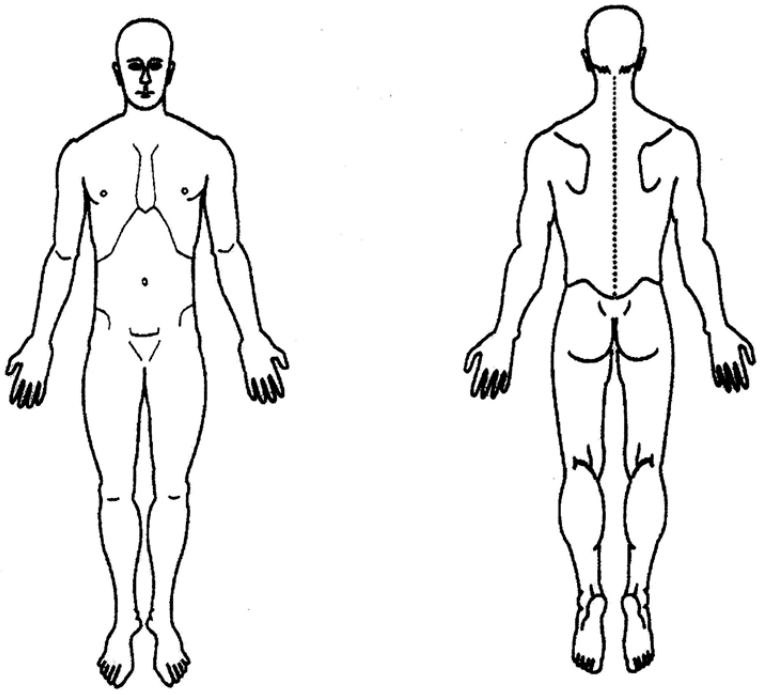
Quality of Movement-Lumbar-Pelvic Rhythm:

Provocative Maneuvers :

Forced Extension	
Forced Extension w/ rotation	L _____ R _____
Pelvic Rock Test	L_____R _____
Fabere	L_____R _____
Flip Test	L _____ R _____
Piriformis Motor	L _____ R _____
SLR	L _____ R _____
Lasegue's	L _____ R _____
Piriformis Stretch	L _____ R _____
Gaenslen's Sign	L _____ R _____
Femoral Stretch Test	L _____ R _____

ROM:

Flexion (60)	
Schober's Test	
Extension (25)	
Later Flexion	L_____ R _____
Rotation	L _____ R _____



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