

**Premier Sports and Spine Rehabilitation
Initial Medical History Intake Form**

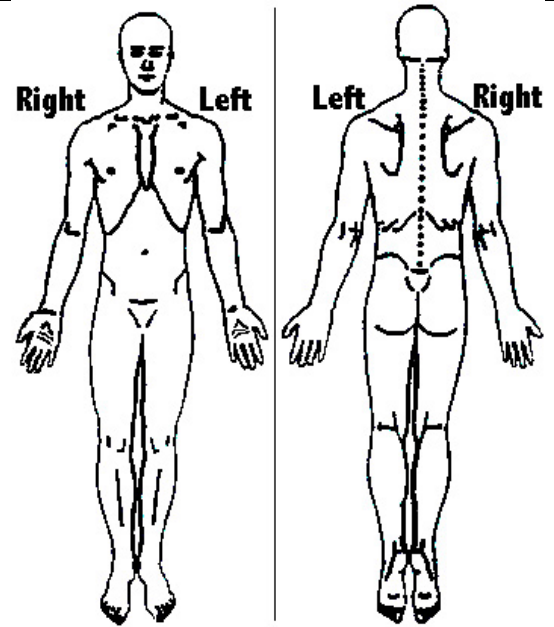
Last Name _____ First Name _____ Date ____/____/____ Age ____

Referred By _____ Date of Birth ____/____/____ Handedness: Right / Left

• Weight change, night pain, fevers?	Yes	No	
• Vision change, double vision?	Yes	No	
• Difficulty swallowing, headaches?	Yes	No	
• Chest pain, palpitations?	Yes	No	
• Shortness of breath, asthma?	Yes	No	
• Nausea, vomiting, black stools, stool incontinence?	Yes	No	
• Urinary or prostate/gynecologic problems?	Yes	No	
• Rashes?	Yes	No	
• Dizziness, weakness, numbness, tingling?	Yes	No	
• Depression, sleep problems?	Yes	No	
• Prior nerve, muscle, bone or joint injuries?	Yes	No	
• What do you do for exercise?			

Allergies to Medicines	
Your Other Medical Problems (eg. diabetes, cancer, heart attack, arthritis)	
Medications Prescription, Over-the-Counter (ie Advil), Birth Control, Vitamins	
Past Surgeries All Surgeries, Broken Bones, Accidents, Injuries	
Family History (ie cancer, arthritis, osteoporosis)	
Occupation	

Please draw the location of your discomfort



Employment status	Full-time	Part-time	Light Duty	Off Duty due to injury	Retired	Not working
Tobacco use	Current	Quit	Never	Packs per day?		For how many yrs?
Alcohol use	Yes	No		Drinks per week?		Recreational drug use?

What problem brings you here today? _____

How and when did it start? _____

What activities/treatments have made it worse? _____

What activities/treatments have made it better? _____

Is this a work related injury?	Yes	No	What tests have you had?	X-rays	Yes	No
Is there litigation pending?	Yes	No		EMG	Yes	No
What treatments have you had?	Chiropractic	Yes		No	MRI	Yes
	Physical Therapy	Yes	No			

Please make a mark on the line below to indicate the level of discomfort you have today

No Pain _____ Worst Pain Ever

0 1 2 3 4 5 6 7 8 9 10

Health Care Provider Initials _____