MEDICAL HISTORY

Name: _____ Date: _____

1. Please rate your ***overall*** health. ***Circle only one (1):*** Good Fair Poor

   Please check ***ALL*** of the following that apply:

   - ☐ Alzheimer's
   - ☐ Cardiovascular Disease
   - ☐ Cauda Equina Syndrome
   - ☐ Cerebral Vascular Accident
   - ☐ Current Infection
   - ☐ Diabetes Mellitus Type 1
   - ☐ Diabetes Mellitus Type 2
   - ☐ Fibromyalgia
   - ☐ Fracture Or Suspected Fracture
   - ☐ High Blood Pressure
   - ☐ History of Cancer
   - ☐ Huntington's
   - ☐ Immunosuppression
   - ☐ Lupus
   - ☐ Muscular Dystrophy
   - ☐ Obesity
   - ☐ Osteoarthritis
   - ☐ Parkinson's
   - ☐ Rheumatoid Arthritis
   - ☐ Traumatic Brain Injury
   - ☐ Other: _____

2. Please rate your pain ***today*** on a scale of 0-10, with (0) being *no pain* and (10) being pain that is so bad you would be headed to the emergency room:

   0 1 2 3 4 5 6 7 8 9 10

3. Now rate your pain ***at worst*** from 0-10:

   0 1 2 3 4 5 6 7 8 9 10

4. Select ***one (1)*** of the faces below to indicate your pain:

5. Please indicate past therapy or surgeries: _____

6. Do you have any allergies? **Yes** **No** If yes, please indicate: _____

7. Have you been with a fall or falls in the ***last 6 months***? **Yes** **No** If yes, please *briefly* explain below:

   _____

8. Have you had any imaging for your injury? **Yes** **No**

   If yes, please indicate: ☐ MRI ☐ CT Scan ☐ X-ray Other: _____

   Where was this imaging performed? _____

Outcomes:

The following page(s) include a questionnaire that is related to your area of injury or surgical care. This will help in determining progress that is seen from your treatment. Please take a moment to read it carefully and complete each question.

→ Please circle ***ONE (1)*** number according to each question.

→ Each question ***must*** be answered so please select the number that best describes your condition.