THE PERFORMANCE & HEALTH INSTITUTE

REASON FOR APPT:
___SPORTS MEDICINE ___MASSAGE THERAPY ___ALTERNATIVE MEDICINE
___NUTRITION /WEIGHTLOSS ___MEDICAL PROBLEM ___ORTHOPEDIC COMPLAINT
___ACUPUNCTURE ___PHYSICAL THERAPY ___OTHER
___CHIROPRACTIC ___PAIN MANAGEMENT

IF INJURED, WHAT BODY PART: _____ SIDE OF BODY: LEFT____ RIGHT____ BILATERAL _____
INJURY DATE: _____ SPECIALIZED APPT: CONSULTATIONS OR 2ND OPINION
PLEASE BRIEFLY DESCRIBE: _____
WERE YOU SEEN IN THE EMERGENCY ROOM: _____ IF YES, WHERE: _____

CURRENT SYMPTOMS: ___PAIN ___SWELLING ___STIFFNESS ___NUMBNESS ___WEAKNESS
HOW LONG HAVE YOU HAD THESE SYMPTOMS: _____
DIAGNOSTIC TREATMENTS: ___X-RAYS ___MRI ___BLOODWORK ___OTHER
PREVIOUS TREATING PHYSICIAN NAME & NUMBER: _____

PLEASE RATE THE SEVERITY OF PAIN 1= MINIMUM AND 10=MAXIMUM 0 1 2 3 4 5 6 7 8 9 10
CURRENT _____ AT WORK _____

IS YOUR COMPLAINT A RESULT OF A WORK RELATED INJURY/WORKERS COMPENSATION, CAR ACCIDENT/NO FAULT ISSUE, OR ANY OTHER INJURY _____ YES _____ NO
IF YES PLEASE FURNISH YOUR LAWYER 'S NAME, PHONE NUMBER AND CASE#: _____

PAST MEDICAL HISTORY

HAVE YOU EVER HAD:

____ANXIETY ____ASTHMA/PULMONARY CONDITION ____COPD
____CORONARY ARTERY DISEASE ____DEPRESSION ____DIABETES MELLITUS
____EDEMA ____HEARTBURN ____HYPERLIPIDEMIA
____HYPERTENSION ____HYPERTHYROIDISM ____KIDNEY STONES
____LIVER DISEASE ____HYPOTHYROIDISM ____MIGRAINES
____OSTEOARTHRITIS ____SEIZURE ____STROKE
____PROSTATE CANCER ____GASTRITIS ____ANEMIA
____AUTOIMMUNE CONDITIONS ____TRAUMA ____ALLERGIES (eg. Sinus, Food)
____SKIN CANCER ____OTHER CANCER OTHER:_____

ARE YOU CURRENTLY ON ANY MEDICATIONS? YES OR NO (PLEASE CIRCLE ONE):

NAME: _____ NAME: _____ NAME: _____
DOSAGE: _____ DOSAGE: _____ DOSAGE: _____
FREQUENCY: _____ FREQUENCY: _____ FREQUENCY: _____

ARE YOU ALLERGIC?

MEDICATION: _____ FOODS: _____ SEASONAL: _____

SURGICAL HISTORY

____TONSILS ____OVARY ____HERNIA REPAIR
____APPENDIX ____UTERUS ____OTHER: _____
____GALL BLADDER ____SPINE SURGERY: _____ ____ORTHOPEDICS: _____

INITIAL: _____ DATE: _____

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	☐ Difficulty walking
PSYCHIATRIC HEALTH	☐ Memory loss or confusion ☐ Nervousness or anxiety ☐ Depression ☐ Insomnia ☐ Difficulty concentrating
NEUROLOGICAL SYSTEM	☐ Frequent or recurring headaches ☐ Light-headed or dizzy ☐ Convulsions or seizures ☐ Numbness or tingling sensations ☐ Tremors or shaking ☐ Paralysis ☐ Stroke ☐ Head injury ☐ Poor balance
GENITOURINARY SYSTEM	☐ Frequent urination ☐ Burning or painful urination ☐ Blood in urine ☐ Change in force of strain when urinating ☐ Incontinence or dribbling ☐ Kidney stones ☐ Sexual difficulties ☐ Genital infections or sexually transmitted disease (STD) ☐ Male – testicle pain or swelling ☐ Female – pain with periods ☐ Female – irregular periods ☐ Female – vaginal discharge ☐ Female – number of pregnancies _____ ☐ Female – number of miscarriages _____ ☐ Female – date of last Pap smear _____
INTEGUMENTARY SYSTEM (skin, hair, nails) & BREAST HEALTH	☐ Skin rash or itching ☐ Hair loss or other scalp problems ☐ Changes in nail growth or condition ☐ Breast pain ☐ Breast lump
ENDOCRINE SYSTEM	☐ Thyroid disease ☐ Diabetes (insulin or non-insulin) **circle one** ☐ Excessive thirst or urination ☐ Heat or cold intolerance
HEMATOLOGIC & LYMPHATIC SYSTEMS	☐ Bleeding or bruising tendency ☐ Anemia (low red blood cell levels) ☐ Varicose (enlarged or twisted) veins in legs ☐ Past blood transfusions

Employee Review Initials

Initial: _____ Date: _____

FAMILY HISTORY

____CARDIAC DISEASE ____DIABETES ____OSTEOARTHRITIS
____CANCER ____STROKE ____OTHER:_____
RELATIONSHIP TO SELF: _____

SOCIAL HISTORY

DO YOU:

SMOKE Y OR N PACKS PER DAY _____ YEARS_____
CONSUME ALCOHOL Y OR N DRINKS PER DAY _____ WEEK _____

SYSTEMS REVIEW: **DO YOU NOW HAVE OR EVER HAD:** (check all that apply)

CONSTITUTIONAL SYMPTOMS	☐ Recent weight change (gain or loss) ☐ Fever ☐ Fatigue or general weakness
EYES / VISION	☐ Eye disease or injury ☐ Wear glasses or contact lenses ☐ Blurred or double vision ☐ Glaucoma
EARS NOSE MOUTH & THROAT	☐ Hearing loss or ringing in ears ☐ Chronic sinus problems or rhinitis ☐ Nose bleeds ☐ Bleeding gums ☐ Sore throat, hoarseness, or voice change ☐ Difficulty swallowing ☐ Swollen glands in neck
CARDIOVASCULAR SYSTEM	☐ Heart trouble ☐ Angina pectoris (chest pain, discomfort, or tightness) ☐ Palpitations (irregular or forceful heart beats) ☐ Shortness of breath with walking or lying flat ☐ Swelling of feet, ankles, or hands
RESPIRATORY SYSTEM	☐ Chronic or frequent coughing ☐ Shortness of breath ☐ Asthma or wheezing ☐ Coughing up mucous
GASTROINTESTINAL SYSTEM	☐ Loss of appetite ☐ Change in bowel movements ☐ Nausea or vomiting ☐ Frequent diarrhea ☐ Painful bowel movements or constipation ☐ Rectal bleeding or blood in stool ☐ Abdominal pain ☐ Peptic ulcer (stomach or duodenal) ☐ Frequent heart burn
MUSCULOSKELETAL SYSTEM	☐ Joint pain, stiffness, or swelling ☐ Weakness of muscles or joints ☐ Muscle pain or cramps ☐ Back or neck pain ☐ Cold extremities (hands or feet)

Employee Review Initials

Initial: _____ Date: _____