

Vancouver Spine & Orthopedic Rehabilitation Center, PLLC

MEDICAL HISTORY FORM

Please complete the following

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender [ ] M [ ] F

Do you have a pacemaker? [ ] Yes [ ] No Are you pregnant? [ ] Yes [ ] No

Physical Activities at work: \_\_\_\_\_

General Health: [ ] Excellent [ ] Good [ ] Average [ ] Fair [ ] Poor

Date of Last Physical Exam: \_\_\_\_\_

Activity Level: [ ] None [ ] 1-2 times a wk [ ] 2-3 times a wk [ ] 3-4 times a wk [ ] 5 or more a wk

Type of Activity: \_\_\_\_\_

Do you experience any symptoms during heavy exercise? [ ] Yes [ ] No
If yes, please explain \_\_\_\_\_

Stress Level: [ ] Low [ ] Medium [ ] High

Hobbies: \_\_\_\_\_

Are you currently seeing any of the following?

Medical Doctor [ ] Yes [ ] No Chiropractor [ ] Yes [ ] No Massage Therapist [ ] Yes [ ] No
Physical Therapist [ ] Yes [ ] No Acupuncture [ ] Yes [ ] No
Other \_\_\_\_\_

If you have seen any of the above in the last 3 months, please describe for what reason (illness, medical condition, physical exam, etc.). \_\_\_\_\_

In the past 6 months have you had?

Difficulty with bowel/bladder control Yes /No Fever/Chills Yes/ No Numbness Yes/ No
Vision/hearing problems Yes /No Night Pain/Sweats Yes/ No Weakness Yes/ No
Unexplained weight change Yes/ No Dizziness/Fainting Yes/ No Chest Pain Yes/ No
Shortness of breath Yes/ No Leg Swelling Yes /No Fatigue Yes/ No
Other: \_\_\_\_\_

**Have you ever been diagnosed as having any of the following?**

Cancer	Yes No	If yes what kind?	_____		
Heart Problems	Yes No	Chemical Dependency	Yes No	Depression	Yes No
High Blood Pressure	Yes No	Hepatitis	Yes No	Stroke	Yes No
Asthma	Yes No	Tuberculosis	Yes No	Anemia	Yes No
Emphysema/Bronchitis	Yes No	Rheumatoid Arthritis	Yes No	Kidney Disease	Yes No
Thyroid Problems	Yes No	Other Arthritic Conditions	Yes No	Allergies	Yes No
Diabetes	Yes No	Epilepsy/Seizures	Yes No	Multiple Sclerosis	Yes No
HIV	Yes No	Other:	_____		

**Do you have any of the following risk factors for Heart Disease?**

High blood pressure	Yes No	Diabetes	Yes No
High Cholesterol	Yes No	Smoking	Yes No
Heart Disease	Yes No	Family history of heart disease	Yes No

**Please list any surgeries or conditions for which you have been hospitalized which may pertain to your current condition.**

Date	SURGERY/HOSPITALIZATION	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____

**What medication** including prescription, herbal remedies and over the counter, in any form (pills, injection, and skin patches) are you currently taking?

\_\_\_\_\_

\_\_\_\_\_

**Chief Complaints**

Please Rate your symptoms with "0" meaning no pain, and "10" meaning worse pain imaginable

Chief Complaints	Pain Scale
1. _____	_____
2. _____	_____
3. _____	_____

Symptoms are worse in: [ ] Morning [ ] Afternoon [ ] Night

Symptoms developed from [ ] Job Related [ ] Auto Related [ ] Other

When and how occurred? \_\_\_\_\_

How long have you had these symptoms? \_\_\_\_\_

Have you ever had this before? [ ] Yes [ ] No If yes, when? \_\_\_\_\_

Symptoms are [ ] Deep/Dull [ ] Sharp/Electrical [ ] Constant [ ] Intermittent