Revolution Sport & Spine Therapy

PAST MEDICAL HISTORY

Name: _____

Describe current symptoms: _____

Symptoms present since: ___/___/_____ Symptoms are: Improving / Unchanging / Worsening

Commenced due to: _____ / No Apparent Reason

Occupation: _____

Rate your pain: Worst ___/10 Best ___/10 Now ___/10

What makes it better: _____

What makes it worse: _____

Previous treatments for current condition: _____

Imaging (X-Ray / MRI): Yes / No If Yes, Date: ___/___/_____

Surgery performed: Yes / No If Yes, Date: ___/___/_____

Surgery type: _____ / N/A

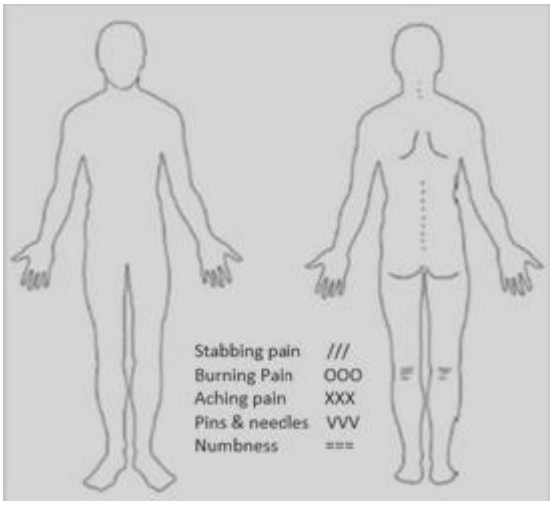
Current functional limitations: None / Minimal / Moderate / Severe

Allergies: _____

Medications: _____

*Please use back of page if needed

Draw your pain on the diagrams shown



Have you recently had:

- ☐ Change in Bowel/Bladder
- ☐ Chills
- ☐ Dizziness
- ☐ Double Vision
- ☐ Difficulty Swallowing
- ☐ Headaches
- ☐ Light Headedness
- ☐ Nausea
- ☐ Night Pain
- ☐ Numbness
- ☐ Shortness of Breath
- ☐ Vertigo
- ☐ Vomiting
- ☐ Weight Loss

Do you have any of the following medical conditions?

- ☐ AIDS / HIV
- ☐ Cancer: _____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes: ☐Type I ☐Type II
- ☐ Epilepsy/Seizures
- ☐ Gastric Reflux/Heartburn
- ☐ Hypertension (High blood pressure)
- ☐ Migraines
- ☐ Muscle Disease
- ☐ Nerve Disorder
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Other: _____

What are your goals related to therapy?

_____

_____

_____