



CACTUS SPORT & SPINE, P.C.

In order to provide you with the best care, we would like you to complete the following:

Name: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____

What are we seeing you for: _____

When did your problem begin (date of accident/onset): _____

Previous and/or Current Treatment (Physical Therapy / Chiropractor / Massage, other):

Tests performed (X-rays, MRI, CT scan, blood Tests): _____

When: _____ Results: _____

Date of last physical examination _____

Other existing/previous injuries: _____

Have you or any immediate family member ever been told you have:

	<u>Self</u>		<u>Family</u>			<u>Self</u>		<u>Family</u>	
Cancer	Yes	No	Yes	No	Stroke	Yes	No	Yes	No
Diabetes.....	Yes	No	Yes	No	Osteoporosis.....	Yes	No	Yes	No
High blood pressure	Yes	No	Yes	No	Osteoarthritis.....	Yes	No	Yes	No
Heart disease	Yes	No	Yes	No	Rheumatoid arthritis...	Yes	No	Yes	No
Angina/chest pain.....	Yes	No	Yes	No					

In the past 3 months have you had or do you experience:

A change in <u>your</u> health	Yes	No	Yes	No	Stroke	Yes	No	Yes	No
Nausea/Vomiting	Yes	No	Yes	No	Difficulty swallowing	Yes	No	Yes	No
Fever/chills/sweats.....	Yes	No	Yes	No	Shortness of breath	Yes	No	Yes	No
Unexplained weight change	Yes	No	Yes	No	Dizziness	Yes	No	Yes	No
Changes in appetite ?	Yes	No	Yes	No	Urinary tract infection	Yes	No	Yes	No
Changes in bowel/bladder function...	Yes	No	Yes	No	Upper respiratory infection	Yes	No	Yes	No

Do you have a history of:

Allergies/Asthma	Yes	No	Yes	No	Seizures.....	Yes	No	Yes	No
Headaches.....	Yes	No	Yes	No	Ulcers.....	Yes	No	Yes	No
Kidney disease.....	Yes	No	Yes	No	Bronchitis.....	Yes	No	Yes	No
Rheumatic fever.....	Yes	No	Yes	No	Sexually transmitted disease.....	Yes	No	Yes	No

Are you currently:

Pregnant	Yes	No	If Yes Due Date :	_____
Depressed.....	Yes	No		
Under Stress	Yes	No		

Do you or have you in the past smoked tobacco? YES NO Last tobacco use _____

Do you drink alcoholic beverages? YES NO If yes, how many drinks per week? _____

Please complete back of form

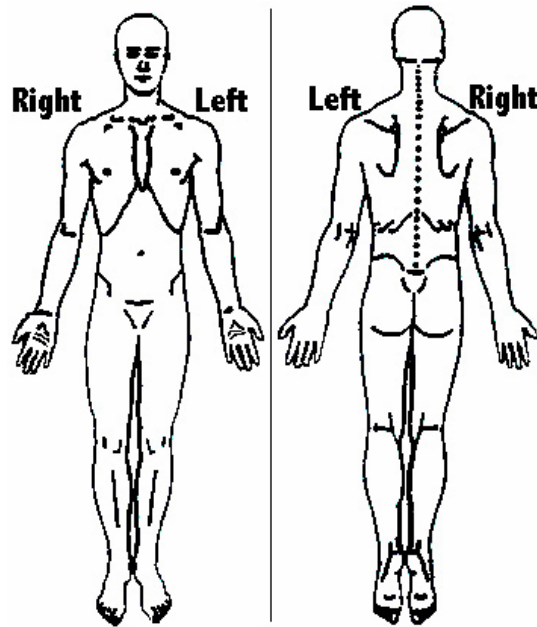
Are your symptoms: (check one)

Getting worse The same Improving

How are you able to sleep at night? (check one)

Fine Moderate difficulty Only with medication

Please draw your area of pain:



How would you rate your pain on a scale of 0 - 10?

(0 - no pain 10 - severe pain)

0 1 2 3 4 5 6 7 8 9 10

What aggravates your pain: _____

What relieves your pain; _____

List medications/supplements currently using: _____

Any other information you would like to provide to your therapist: _____
