Restore Resilience Therapy

Medical Information

Name: _____ Date: _____

Handedness: (Circle) Right Left Both

Date of Injury: _____ Referral Source: _____

Date of surgery: _____ Physician: _____

1. Briefly describe your reasons for seeking therapy (e.g. symptoms, type of injury):

_____

_____

_____

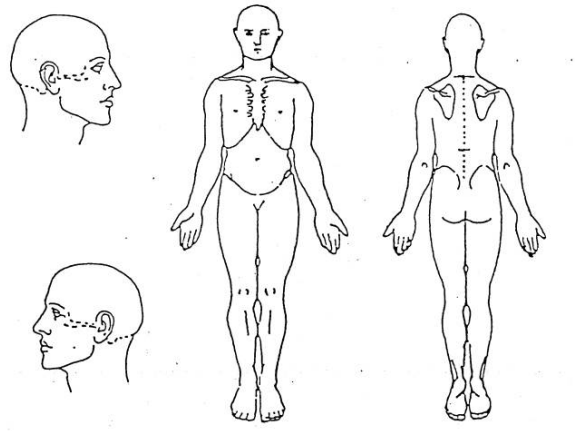
2. What are your treatment goals?

_____

_____

_____

3. Mark pain location (see below) on body chart with X's, and mark numbness with /// shooting pains with -→



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4. Place three circles on the scale below to indicate the intensity of pain/discomfort at its best, on average, and at its worst.

0 1 2 3 4 5 6 7 8 9 10
no pain ……minimal……moderate…….severe ……...…...worst pain imaginable

5. Describe pain (check all that apply):
___ Sharp ____ Dull ____Burning ____ Ache ____ Shooting
___ Tingling ____ Numb ____ Stabbing ____ Pressure ____ Radiating
____ Other (please describe): _____

6. Are your symptoms constant or intermittent? (Circle one)
If intermittent, how often do they occur?: _____
Are you getting better, worse or staying the same? (circle one)

7. What positions or activities increase your pain or symptoms?

_____

_____

_____

8. What positions or activities decrease or relieve your pain or symptoms?

_____

_____

_____

9. Have you seen any other health practitioners for this same or similar condition? If so, please list below the name, title, approximate dates, and type of treatment. Were these treatments beneficial?

_____

_____

_____

_____

_____

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10. Have you had any of the following tests performed for this problem?
Please give dates and results.

Xray _____ EEG: _____ EMG : _____

CT scan:_____ MRI: _____ Arthrogram: _____

Bone scan: _____ Other: _____

11. List all current medications & supplements (including over-the-counter medications, vitamins, herbs, homeopathic remedies). Use back of sheet or separate sheet, if needed.

_____

_____

12. Estimate your usual intake of the following:
Caffeine _____ cups/day Cigarettes _____ packs/day

13. Please check all conditions that apply to you (now or in past):

____ Anemia
____ Aneurysm
____ Anxiety
____ Appetite or weight changes
____ ADD/ADHD
____ Arthritis
____ Autism
____ Asthma
____ Blackouts
____ Blood Clots
____ Bowel/bladder problems
____ Blood pressure (high/low)
____ Cancer
____ Cerebral palsy
____ Circulatory problems
____ Concussion
____ COPD (respiratory)
____ Depression
____ Dentures
____ Diabetes
____ Dislocations
____ Dizziness/vertigo
____ Fatigue
____ Fibromyalgia
____ Fractures
____ Headaches
____ Head injuries
____ Heart condition
____ Hepatitis
____ HIV
____ Intestinal/digestive problems
____ Jaw pain or chewing problems (TMJ)
____ Kidney problems
____ Learning disabilities
____ Migraines
____ Multiple sclerosis
____ Neck or back injuries
____ Orthodontics or major dental work
____ Osteoporosis
____ Pacemaker
____ Pregnancy/childbirth
____ Ringing in ears (tinnitus)
____ Seizures/epilepsy
____ Sinus problems
____ Stroke
____ Swallow problems
____ Teeth clenching or grinding
____ Thyroid problem (high or low)
____ Visual disturbances
____ Other

14. Comments: (Please elaborate as needed, on conditions in #13)

_____

_____

_____

_____

_____

15. List major injuries and surgeries below (include date):

_____

_____

_____

_____

_____

_____

16. Any further comments or concerns:

_____

_____

_____

_____

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