Michael C. Sparr, MD **Stephen M. Scheper, DO** **Dwight R. Leggett, II, MD**
Phone 719 636 3333 **Fax** 719 636 0025

PATIENT HISTORY FORM

Name ______________________________ Age __________ Date ______________________

HISTORY OF PRESENT ILLNESS

1. What medical problem(s) brings you to our clinic? If more than one, please list in order of severity. ______________________________

2. When did this medical problem begin? ______________________________

3. What do you think caused this problem? ❍ Work injury ❍ Auto Accident ❍ Other? ______________________________

4. Please describe how this problem began. (For auto accidents, please complete the auto form. Ask the front desk staff for one if you did not get one in your packet). ______________________________

5. What treatments have you had for this problem so far? (Please list in chronological order).______________________________

6. What imaging (x-rays, MRI) or other tests (EMG) have you had for this problem?______________________________
   When? ______________________________Where? ______________________________

7. What improvement have you had since this problem began? (0-100%) ______________________________

8. On a scale of 0 to 10 (where 0 is no pain and 10 is the worst pain imaginable), what is the level of pain/discomfort you are experiencing right now?__________; at best?__________; at worst?__________; and at its usual level?__________

9. What makes your pain/discomfort better?______________________________
   What makes your pain/discomfort worse? ______________________________

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Name ____________________ Age ________ Date ____________________

ALLERGIES/MEDICATIONS

1. Are you allergic to any medications? ❍ Yes ❍ No Please list medication and reactions (e.g. aspirin – hives) ____________________

____

____

2. Please list all medications you are currently taking: (Attach another page if necessary)

Medication	Strength (e.g. 5 mg)	How often (e.g. two times per day)	Prescribing Doctor

PERSONAL MEDICAL HISTORY

1. Have you had any previous injuries or problems in the area that we are evaluating? ❍ Yes ❍ No

If yes, please describe ____

____

____

2. Please circle if you have ever been treated for the following conditions: (review carefully)

Condition			Condition		
Heart problems	❍ Yes	❍ No	Stroke	❍ Yes	❍ No
High blood pressure	❍ Yes	❍ No	Nerve or muscle disease	❍ Yes	❍ No
Blood clotting problems	❍ Yes	❍ No	AIDS or related disease	❍ Yes	❍ No
Liver disease	❍ Yes	❍ No	Thyroid problems	❍ Yes	❍ No
Ulcers	❍ Yes	❍ No	Drug or alcohol problems	❍ Yes	❍ No
Kidney problems	❍ Yes	❍ No	Arthritis	❍ Yes	❍ No
Cancer	❍ Yes	❍ No	Headaches	❍ Yes	❍ No
Diabetes	❍ Yes	❍ No	Depression	❍ Yes	❍ No
Lung problems	❍ Yes	❍ No	Other psychiatric treatment	❍ Yes	❍ No

3. Please list any other medical conditions and surgeries you have had which are not noted above. If you remember, please include the dates of treatment occurred.____

____

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FAMILY MEDICAL HISTORY

1. Do you have any blood relatives who have a nerve or muscle disease? ❍ Yes ❍ No

2. Do you have any immediate family members who are disabled from work? ❍ Yes ❍ No

3. Please list any medical conditions that run in your family______________________________

____

SOCIAL/EMPLOYMENT HISTORY

1. What is your marital status? ❍ Single ❍ Married ❍ Divorced ❍ Widowed

2. Do you have any children at home? ❍ Yes ❍ No ____________________ Ages ______________

3. What is your current occupation? ______________________________

4. Who is your employer? ______________________________

5. How many years have you been employed at this company?______________________________

6. What are your primary job duties? ______________________________

7. Please provide any work restrictions ordered by a phycian ______________________________

8. Do you have a second job? ❍ Yes ❍ No (If yes, please describe) ______________________________

9. What are your hobbies?______________________________

10. Do you currently smoke? ❍ Yes ❍ No Do you have a history of smoking? ❍ Yes ❍ No

    How many packs per day? ____________ How many years? ____________

11. How many alcoholic drinks on average do you have per week?______________

12. Do you use street drugs? ❍ Yes ❍ No

13. What type of exercise do you do on a regular basis? ______________________________

14. Other than the problems for which we are seeing you, what is the most stressful thing in your life?_______________

____

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REVIEW OF SYSTEMS

Circle any symptoms that you have experienced RECENTLY.

General
Fever/chills
Night sweats
Poor sleep
Fatigue/poor energy level
Poor appetite
Unintentional weight loss

Cardiovascular
Chest pain with exercise
Chest pain at rest
Irregular heart beat
Shortness of breath
Leg swelling
Coldness in hands or feet

Respiratory
Persistent cough
Difficulty breathing

Genitourinary
Loss of bladder control
Pain with urination
Difficulty starting stream
Blood in urine
Urinary tract infection
Abnormal vaginal bleeding
Breast mass or discharge

Gastrointestinal
Belly pain
Heartburn
Nausea
Blood in stool
Constipation
Vomiting
Loss of bowel control
Diarrhea

Rheumatologic
Morning stiffness
Joint swelling
Rash

Neurologic
Headaches
Blackouts
Dizziness
Seizures
Tremors
Blurred vision
Mood swings
Poor memory
Decreased coordination
Weakness (where?) ______________________________
Numbness (where?) ______________________________
Tingling (where?) ______________________________

Hematologic
Easy bruising
Easy bleeding

Endocrine
Frequent thirst
Frequently feeling cold
Rapid weight loss

Psychological
Feelings of depression
Anxiety
Stress

ACCELERATED
RECOVERY SPECIALISTS
Musculoskeletal & Electrodiagnostic Medicine

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Name ______________________ Age __________ Date ______________________

Mark the areas on your body where you feel these sensations. Use the symbols below:

Numbness	Pins and Needles	Ache	Stabbing Pain
= = = =	o o o o	x x x x	/ / / /
= = = =	o o o o	x x x x	/ / / /
= = = =	o o o o	x x x x	/ / / /
= = = =	o o o o	x x x x	/ / / /

Right Left Left Right

Anterior Posterior