File # _____

Confidential Patient Health History

PERSONAL HISTORY

Date _____

Name _____ Home # _____ Work # _____ Cell # _____

Email Address _____ Marital Status __ Height _____ Weight _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age ___ [ ] M [ ] F Social Security Number: _____

Employer _____ Occupation _____ Years _____

Do you have health insurance? [ ] Yes [ ] No Are you covered under spouse's health insurance? [ ] Yes [ ] No

If yes, with what company? _____ Policy # _____

Spouse _____ Employer _____ Work Phone _____

Date of Birth _____ SS# _____ Number of Children ____ Ages of children _____

Who can we contact in case of emergency? _____ Relationship _____ Phone _____

Nearest relative not residing in your home? _____ Relationship _____ Phone _____

How did you find out about Triangle Disc Care? _____

CURRENT HEALTH HISTORY

Describe your major complaint: _____ When did this begin? _____

Has this condition come and gone before this? Yes No When was the very first time? _____

Did anything cause this to happen? Yes No If yes, what? _____

How many "good" days have you had in the past month? ____ / 30. 0 1 2 3 4 5 6 7 8 9 10

(use the scale to the right to rate a "good" day) >>>>>>> No pain Terrible pain

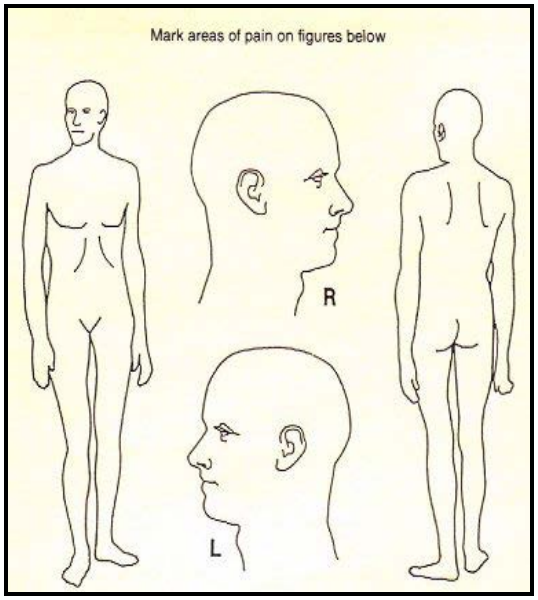
How many "average" days have you had in the past month? ____ / 30. 0 1 2 3 4 5 6 7 8 9 10

(use the scale to the right to rate an "average" day) >>>>>>> No pain Terrible pain

How many "bad" days have you had in the past month? ____ / 30. 0 1 2 3 4 5 6 7 8 9 10

(use the scale to the right to rate a "bad" day) >>>>>>> No pain Terrible pain

[USE THE DIAGRAM TO SHOW AREAS OF PAIN]



On an average day, when you first open your eyes in the morning the pain is:

0 1 2 3 4 5 6 7 8 9 10

On an average day, when you get out of the bed the pain is:

0 1 2 3 4 5 6 7 8 9 10

On an average day, by mid-day the pain is:

0 1 2 3 4 5 6 7 8 9 10

On an average day, in the evening after work the pain is:

0 1 2 3 4 5 6 7 8 9 10

On an average day, when you go to bed the pain is:

0 1 2 3 4 5 6 7 8 9 10

Who is your primary care physician? _____ Phone #_____

Would you like a report sent to your primary care physician detailing our findings and recommendations? Yes No

Is there any drug you now take every week for this condition? Yes No (*** LIST BELOW ***)

Drug 1: _____ Purpose: _____

Drug 2: _____ Purpose: _____

Drug 3: _____ Purpose: _____

Have you ever had a cortisone shot for this condition? Yes No When? _____ Result? _____

Have you had epidural injections for this condition? Yes No When? _____ Result? _____

Have you had physical therapy for this condition? Yes No When? _____ Result? _____

Have you had acupuncture for this condition? Yes No When? _____ Result? _____

Have you had chiropractic for this condition? Yes No When? _____ Result? _____

Have you had massage therapy for this condition? Yes No When? _____ Result? _____

Have you had surgery for this condition? Yes No When? _____ Result? _____

Have you been given a TENS unit for this condition? Yes No When? _____ Result? _____

Have X-rays or an MRI or a CT scan been taken? Yes No Where? _____ Date (s) _____

Has an EMG or an NCS or a SSEP scan been done? Yes No Where? _____ Date (s) _____

Has a Bone Scan been done? Yes No Where? _____ Date (s) _____

Has a Myelogram or a Discogram been done? Yes No Where? _____ Date (s) _____

Is there any drug you now take every week for *any other* condition? Yes No (*** LIST BELOW ***)

Drug 1: _____ Purpose: _____

Drug 2: _____ Purpose: _____

Drug 3: _____ Purpose: _____

What is your occupation? _____

Are you presently able to work? Yes No Have you missed work in the past due to this problem? Yes No

In the past year how many days work have you missed as a result of this condition? _____

If you are permanently disabled indicate the date of disability: _____ /_____ / _____

Assign a percentage to how much time you spend on each of the activities below in an average work day:

Sitting _____ % Standing _____ % Walking _____ % Lifting _____ %

Which of these activities causes you the most difficulty? _____

Is there a history of spinal problems or nerve disorders in your family? Yes No

Describe: _____

Have you had spinal surgery in the past? Yes No Dates: _____

If you have had surgery, do you have screws/plates/rods/other metal implanted ? Yes No

Has surgery been recommended as a possible solution to this condition? Yes No

Has anyone else in your family had spinal surgery? Yes No Who? _____ How many times? _____

If yes, what was their result? _____

Have you noticed any muscle weakness in your arm or leg? Yes No

Have you noticed any difficulty controlling your bowel / bladder? Yes No

Does this condition interfere in any way with your sex life? Yes No

Do you suffer from any condition other than that which you are now consulting us? Yes No

Please Explain: _____

PAST HEALTH HISTORY

Any major surgery/operations? Yes No Any broken bones? Yes No

Describe: _____

Any major accidents or falls? Yes No

Describe: _____

Anything (other than above) resulting in hospitalization? Yes No

Describe: _____

Is it possible you are pregnant? Yes No Last menstrual period: _____

Is there *anything else* the doctor should know about you regarding your health? Yes No Please explain in the area below:

SELF-ASSESSMENT INDEX

Subjective Findings

FOR EACH of the thirteen (13) categories listed below please indicate the degree to which different aspects of your life are affected by the function of your body. Think about the past 30 days. A score of 0 means no problem at all, and a score of 10 signifies that all of the items described in the category have been totally disrupted or prevented by pain or dysfunction.

1. Exercise. Do you exercise? A physically demanding job is worth several extra points but is not exercise. Do you know how to calculate your target heart rate? Do you reach your target heart rate for at least 20 minutes, 3 times a week? Do you have a stretch routine? Have you heard the old saying "if you don't use it, you lose it"? How much improvement is needed in this category?

0 1 2 3 4 5 6 7 8 9 10

I've exercised regularly for years — I need to get in a lot better shape

2. Self Care. This category includes activities that involve personal maintenance and independent daily living such as showering and shaving. Do you have to rest between showering and getting dressed? If you drop something on the floor is it a problem? Do you leave extra time to get ready? Does it take you a long time to "get going" in the morning?

0 1 2 3 4 5 6 7 8 9 10

I have no problem — This is a terrible problem

3. Activities of Daily Living. This category refers to such general activities such as sitting, walking, standing, getting out of a chair, lifting, etc. Do you have to be careful about which chair you choose to sit in? Does standing in line aggravate your symptoms? Are there certain shoes that you can no longer wear? Do you have trouble getting into or out of the car or driving for much distance?

0 1 2 3 4 5 6 7 8 9 10

I have no problem — Everything I do causes me pain

4. Stress. This category refers to the general feeling of being "stressed out". Stress can result in headaches, irritability, moodiness, fatigue, inability to concentrate, tension behind the eyes, difficulties with sleep (including inability to get to sleep or awakening too early), and others. Do you take drugs to control these symptoms? Zero (0) equals light-hearted, well rested, and full of energy. Ten (10) equals completely stressed out, tired, and drained almost all the time.

0 1 2 3 4 5 6 7 8 9 10

I have no problem — I have all the sign of stress

5. Family/ Home Responsibilities. Rate the affect of your current physical condition on your family. This category includes the chores and duties you should be doing around the house (e.g., yard work or vacuuming or cooking) and errands or favors for other family members (e.g., driving the children to soccer practice or helping them with homework or shopping at the store). Who pushes the trash can to the street? Could you cut the grass if you chose to do so?

0 1 2 3 4 5 6 7 8 9 10

I have no problem — My family life is completely disturbed

6. Social Activity. This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, movies, concerts, dining out, barbecues, and other social functions. Are there things you are missing out on because you don't want to drive that far, stand or sit that long, or walk that much?

0 1 2 3 4 5 6 7 8 9 10

I have no problem — I've stopped all social activities because of the pain

7. Recreation. This category includes hobbies such as reading or crossword puzzles, sports such as basketball or golf, and other similar leisure or fun activities such as shopping at the mall or browsing through the fair grounds. Are there things you used to do, that others your age can still do, that are no longer worth the price you have to pay?

0 1 2 3 4 5 6 7 8 9 10

I have no problem — It's just not worth it

8. Occupation. This category refers to activities that are a part of or directly related to one's job. Do you have trouble lifting? Do you drop things? Are you unable to concentrate? Can you easily sit or stand for as long as you need to? Does an ordinary work day seem like a hundred years? Has anyone at work noticed that you're not doing as well as you could or should?

0 1 2 3 4 5 6 7 8 9 10

I have no problem — My job is in jeopardy

9. Metabolism. This category refers to the hormonal organs such as the thyroid and pancreas, the circulatory system such as the heart and blood vessels, and the filtering organs such as the liver, kidneys and spleen. A few of the symptoms and conditions indicating metabolism problems include: blood sugar problems, blood pressure problems, extreme fatigue, loss of sex drive, inability to lose weight, recurrent skin conditions, bad breath, often feeling too hot or too cold?

0 1 2 3 4 5 6 7 8 9 10

I have no problem — This is a terrible problem

10. Digestive. As an example, suppose you had minor heartburn once or twice in the past 30 days, but you didn't have to take a Tums or Rolaids and it didn't prevent you from sleeping well or have any other negative impact on your life - score yourself 1 or 2. Suppose you had minor to moderate heart burn some of the last 30 days, but taking Tums and Rolaids controls the symptoms with only a few nights when your sleep was interrupted - score yourself 3, 4, 5, or 6. Suppose that during the last 30 days you have had to continually be careful of what you eat, often taking Tagamet, Zantac or other drugs to prevent the symptoms - score yourself 7, 8, or 9.

0 1 2 3 4 5 6 7 8 9 10

I have no problem — Everything I eat disagrees with me

11. Colds/ Sinus/ Allergy. This section refers to the immune system - the body's defense system. Signs and symptoms indicating a lowered immune system include frequent or severe colds, sinus trouble, frequent or severe headaches, allergies, bladder infections, yeast infections, and others.

0 1 2 3 4 5 6 7 8 9 10

I have no problem — This is a terrible problem

12. Nutrition. This category refers to the quality of the fuel that you put into your body. Mentally choose a number as your first impression - remember, everyone gets defensive and claims to practice good nutritional habits. Signs and symptoms that indicate that the fuel is either of poor quality or that your body is unable to properly utilize the nutrients are: indigestion, heart burn, belching, gas, ulcers, constipation, diarrhea, nausea, food allergies, etc. In the past 30 days how would you rate your intake of fresh fruits, fresh vegetables, and salads? Add a point if you have not had fresh fruit within the last 3 days – add 2 points if it has been a week or more. Do you maintain a diet low in sugar and low in fat? Add a point if you had cookies or candy as a snack within the last 3 days – add 2 points if you have eaten cookies or candy so far today. Do you take nutritional supplements? If not, add at least 1 more point. Water is essential to all life on earth. How much water do you drink daily? Add another point if you don't know. Now circle the number you calculated. How much improvement is needed in this category?

0 1 2 3 4 5 6 7 8 9 10

Good nutrition habits — I need to do better

HOW MANY OUNCES OF WATER DO YOU DRINK DAILY? _____ ounces

List the nutritional supplements / vitamins that you take daily: _____

13. Behavioral. This category refers to general habits affecting overall health such as smoking, alcohol, caffeine (coffee or sodas), poor diet, over-eating, lack of exercise, inadequate sleep, and others. Mentally choose a number - remember, everyone gets defensive and considers their own behavior normal, be objective. Add 1 point to your mental number if you have smoked even one cigarette within the last 3 days; add an extra point if you smoke more than a pack a day. Add an extra point if you drink more than 2 cups of coffee or 2 cans of soft drinks a day. Add still another point if you have had more than 3 alcoholic drinks in the past week. Add an extra point if these 3 drinks were on the same day. Is good health a priority for you? Is there room for improvement in this category? Now circle the number you have calculated.

0 1 2 3 4 5 6 7 8 9 10

My mother would be very proud — Poor health habits

Patient Name _____ Date _____