BRADENTON EAST INTEGRATIVE MEDICINE – DIVISION OF NEUROMUSCULOSKELETAL MEDICINE AND NON-SURGICAL ORTHOPEDICS

MUSCULOSKELETAL HISTORY FORM (ESTABLISHED PATIENT WITH NEW COMPLAINT)

PATIENT NAME _____ AGE _____ DOB_____

1) **REASON FOR THIS VISIT:**

_____

_____

2) **PRIMARY CARE PHYSICIAN:** _____ **LAST VISIT:** _____
3) **DO YOU SEE A PAIN MANAGEMENT PHYSICIAN:** ☐ Yes ☐ No
NAME: _____ **LAST VISIT:** _____

4) **IS THIS THE RESULT OF AN INJURY OR ACCIDENT? IS THIS A WORKER'S COMPENSATION OR AUTOMOBILE INSURANCE RELATED CASE?** ☐ Yes ☐ No_____

_____

5) **PRIMARY AREA YOU WOULD LIKE TO DISCUSS TODAY: (please check one)**

☐ Neck/Upper back ☐ Mid-back/Lower Back ☐ Shoulder ☐ Elbow
☐ Wrist ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Foot

Comments: _____

6) **THE FOLLOWING QUESTIONS PERTAIN TO THE PRIMARY AREA YOU'VE CIRCLED IN QUESTION 4 ABOVE :**

a) When and how did this **problem start**? _____

_____

b) How would you describe the **character** of your pain or complaint (check all that apply):

☐ Aching ☐ Tightness/Stiffness ☐ Numbness/Tingling ☐ Cramping ☐ Stabbing
☐ Sharp ☐ Shooting ☐ Pressure ☐ Burning ☐ Weakness

c) Does this pain/complaint **radiate** to any other locations? (if yes, describe the pattern) _____

_____

d) **How severe** is the pain/complaint **currently** on a scale of 0 (no pain) to 10 (most severe pain)?

_____

e) **How severe** is the pain/complaint **on average** on a scale of 0 (no pain) to 10 (most severe pain)?

_____

f) Is this pain/complaint **constant**? ☐ Yes ☐ No
i) **How much of the day** is your discomfort or pain present?
☐ Less than 1 hour ☐ 4 hours ☐ 6 hours ☐ 12 hours ☐ 18 hours ☐ 24 hours

g) How has this pain/complaint **changed over time**?
☐ getting better ☐ getting worse ☐ no change

h) What **activities** is this pain/complaint affecting? _____

_____

i) What makes this pain/complaint **worse**? _____
   i) Does it get worse with bending the area? (eg. For back pain, is it worse with bending forward, backwards, or with twisting?) _____

   ii) Does it get worse with sneezing or coughing? ☐ Yes ☐ No

j) What makes this pain/complaint **better**? _____

_____

   i) Is it better at certain times of day? _____

   ii) Is it better with ☐ rest or ☐ motion?
   iii) Are there certain positions that ease the problem?

_____

   iv) Have you taken any **Medications/Botanical Herbs/Supplements** for this problem?
   (1) Please list:

Name	Dose	Length of Time Taken	Helpful (Not at all/Mildly/Moderately/Very)

   v) Have you had **Physical Therapy** for this problem? ☐ Yes ☐ No When? _____
   For how long? _____

   vi) Have you had **Manual Adjustments** (e.g Chiropractic or Osteopathic) for this problem?
   ☐ Yes ☐ No When? _____ For how long? _____

   vii) Have you had **Acupuncture** for this problem? ☐ Yes ☐ No When? _____
   For how long ? _____

   viii) Have you had **Massage** for this problem? ☐ Yes ☐ No When? _____
   For how long ? _____

   ix) Have you had any **Injections** for this problem? ☐ Yes ☐ No When? _____
   What kind? _____For how long/How many times?

_____

   x) Have you had any **other treatment interventions** for this problem? ☐ Yes ☐ No
   When? _____ For how long/How many times? _____

7) **HAVE YOU RECEIVED ANY SPECIAL TESTING OR PROCEDURES FOR THIS PROBLEM? (PLEASE BRING COPIES OF REPORTS OR HAVE SENT TO US)**

TEST	DATE	LOCATION	RESULTS (in your own words is ok)
XRAY			
CAT SCAN (CT)			
MRI			
ULTRASOUND			
EMG/Nerve Conduction			
OTHER (please specify)			

REVIEW OF SYSTEMS/SYMPTOMS

(Check any symptoms or findings that you have experienced recently)

CONSTITUTIONAL ☐ weight change ☐ fatigue ☐ fever ☐ night sweats ☐ general weakness
EYES ☐ vision problems ☐ double vision ☐ yellowing of the eyes
ENT ☐ hearing problems ☐ dizziness ☐ sinus trouble ☐ sore throat ☐ periodontal disease
CARDIOVASC ☐ shortness of breath ☐ chest pain ☐ leg swelling ☐ increased blood pressure
RESPIRATORY ☐ cough ☐ coughing up blood ☐ wheezing ☐ asthma ☐ other difficulty breathing ☐ snoring ☐ gasping for air during sleep ☐ fall asleep during the day
GASTROINTESTINAL ☐ trouble swallowing ☐ heartburn ☐ nausea ☐ vomiting ☐ diarrhea ☐ blood or black tarry stools ☐ abdominal pain ☐ gas ☐ bloating
GENITOURINARY ☐ pain with urination, blood in urine ☐ urgency ☐ incontinence ☐ increased urination ☐ impotence/erectile dysfunction (for males) ☐ prostate problems (males)
MUSCULOSKELELTAL ☐ joint pain ☐ joint stiffness ☐ muscle cramps ☐ muscle twitching ☐ muscle weakness ☐ loss of motion ☐ tendonitis ☐ swelling of finger or other joints ☐ redness of joints
SKIN/HAIR/NAILS ☐ rash ☐ lumps/masses ☐ itchy ☐ dryness ☐ hair/nail changes ☐ yellowing of the skin
NEUROLOGICAL ☐ fainting ☐ blackouts ☐ seizures ☐ paralysis ☐ weakness ☐ numbness ☐ memory loss ☐ numbness in a saddle distribution (inner legs and groin)
PSYCHOLOGICAL ☐ nervousness ☐ tension ☐ mood changes ☐ depression ☐ anxiety
ENDOCRINE ☐ decreased libido ☐ heat or cold intolerance ☐ excessive thirst ☐ increased hunger ☐ increased craving for sweets or carbs ☐ low blood pressure ☐ hot flashes
HEMATOLOGY/ONCOLOGY ☐ easy bruising ☐ bleeding (difficulty clotting) ☐ current or history of cancer