INFINI HEALTH

CONFIDENTIAL
Medical History Form

Name:_____ **Age:**_____

DOB:_____ **Dominant Hand:**_____

PHN:_____ **Occupation:**_____

What are your most significant symptoms? _____

What additional symptoms are you experiencing? (Please mark all the apply)

- ☐ Pain
- ☐ Numbness
- ☐ Weakness
- ☐ Swelling
- ☐ Stiffness

When did your symptoms start? _____

Did the symptoms occur?

- ☐ Acutely
- ☐ Gradual

Please indicate the cause of your symptoms.

- ☐ Motor Vehicle Collision
- ☐ Fall
- ☐ Sporting
- ☐ Work or School

Other: _____

Describe the Event / Mechanism:_____

If applicable:

Seat Belt Worn: Yes☐ or No☐
Helmet Worn: Yes☐ or No☐
Did you lose consciousness? Yes☐ or No☐
Did you forget details of the event? Yes☐ or No☐
Were you able to move the injured body part? Yes☐ or No☐

Did you have symptoms like this before?

- ☐ Yes - Please explain: _____
- ☐ No

What part of the body is involved?

Right☐ Left☐ Both☐

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- ☐ Shoulder
- ☐ Elbow
- ☐ Wrist/Hand
- ☐ Buttock
- ☐ Hip
- ☐ Knee
- ☐ Foot/Ankle
- ☐ Neck (Cervical Spine)
- ☐ Midback (Thoracic Spine)
- ☐ Back (Lumbar Spine)

Current Symptoms

- ☐ Constant
- ☐ Intermittent: If intermittent, how often do the symptoms occur: _____

How severe is your pain? (please specify the number that best describes your pain level)
On a scale 1 – 10 (10 is the worst)

At Best: _____
At Worst: _____
On Average: _____

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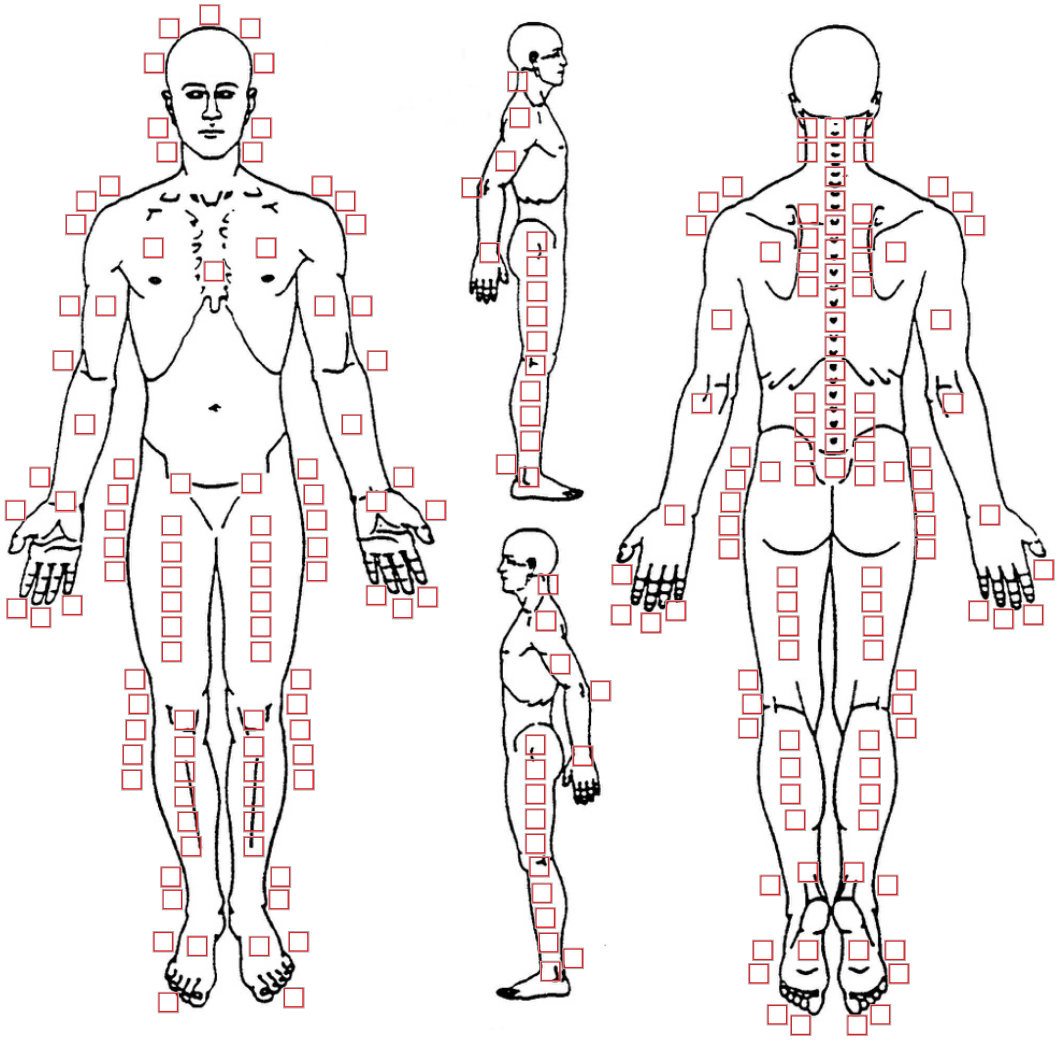
Please Complete the Pain Drawing
Please mark by using Xs on the drawings where you feel pain right now.



Associated Symptoms:

- ☐ Swelling
- ☐ Redness
- ☐ Weakness
- ☐ Giving Way/Buckling
- ☐ Popping Bruising
- ☐ Clicking
- ☐ Locking/Catching

Does your pain wake you from sleep?

- ☐ Yes - Please explain: _____
- ☐ No

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What makes your symptoms worse?

- ☐ Lying in bed
- ☐ Standing
- ☐ Walking
- ☐ Sitting
- ☐ Driving
- ☐ Squatting
- ☐ Kneeling
- ☐ Sports/Exercise
- ☐ Pushing/Pulling
- ☐ Getting out of a bed
- ☐ Getting out of a chair
- ☐ Bending forward/backwards/sideways
- ☐ Other: _____

What medications have you tried? Did they make your symptoms better (Check and Circle)?

- ☐ Tylenol
- ☐ Ibuprofen/Advil/Motrin/Aleve/
- ☐ Prescription anti-inflammatories
- ☐ Nortriptyline/Amitriptyline
- ☐ Gabapentin/Lyrica
- ☐ Cymbalta
- ☐ Tramacet/Tramodol/Ultram
- ☐ Tylenol #3
- ☐ Percocet
- ☐ Morphine
- ☐ Oxycodone/OxyContin
- ☐ Other: _____

What treatments have you tried? Did they make your symptoms better?

- ☐ Ice
- ☐ Heat
- ☐ Elevation
- ☐ Massage
- ☐ Acupuncture
- ☐ TENS
- ☐ Inophoresis
- ☐ Physiotherapy
- ☐ Occupational Therapist
- ☐ Chiropractor
- ☐ Manipulation
- ☐ Active Release Therapy
- ☐ Braces/Splints
- ☐ Naturopath
- ☐ Herbalist
- ☐ Other: _____

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Have you had any Interventions (Injections)?

Injection Type	When	Reaction
NSAIDs (Anti-inflammatories)		
Steroids		
Visco-Supplements		
Blood Products (PRP or Other)		
Stem Cells		
Trigger Point Anesthetic (Lidocaine)		
Trigger Point (Botox or Steroid)		

ADDITIONAL SYPMTOMS

Have you had any fractures (broken bones) in the past?

☐ Yes - Please explain: _____
☐ No

Have you experienced any bowel changes related to current problem?

☐ Yes - Please explain: _____
☐ No

Have you experienced any bladder changes related to current problem?

☐ Yes - Please explain: _____
☐ No

Have you experience any of the following (Constitution Symptoms)?

☐ Fever
☐ Chills
☐ Weight Loss
☐ Night Sweats
☐ Not Applicable

Have you experienced any problems related to balance (falls) and coordination?

☐ Yes - Please explain: _____
☐ No

Do your other joints have symptoms of the following?

☐ Morning stiffness lasting over 30 minutes
☐ Pain
☐ Swelling
☐ Redness
☐ Fracture (Broken Bones) at the site of pain
☐ Not Applicable

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What are your limitations at home or at work?

- ☐ Sleep
- ☐ Hygiene
- ☐ Dressing
- ☐ Walking
- ☐ Sitting
- ☐ Other: _____

PAST MEDICAL HISTORY / HOSPITALIZATIONS / SURGICAL HISTORY

Do you see a physician for any reason?

- ☐ Yes - Please explain: _____
- ☐ No

List all related and unrelated medical problems:

- ☐ Medical Issue #1: _____
- ☐ Medical Issue #2: _____
- ☐ Medical Issue #3: _____

List all related and unrelated surgeries:

- ☐ Procedure #1: _____
- ☐ Procedure #2: _____
- ☐ Procedure #3: _____

List all medications:

- ☐ Medication #1: _____
- ☐ Medication #2: _____
- ☐ Medication #3: _____

List all allergies:

- ☐ Latex (rubber materials like gloves, condoms, balloons or food such as bananas, avocados, papayas, or kiwi fruit)
- ☐ Anti-inflammatory based drugs
- ☐ Penicillin based drugs
- ☐ Sulfa based drugs
- ☐ Anesthetics: Novocaine /Lidocaine/Bupivacaine
- ☐ Opioid based drugs (Codeine/Vicodin/Percocet/Oxycodone/Other)
- ☐ Cortisone (Steroid)
- ☐ Allergy #1: _____
- ☐ Allergy #2: _____
- ☐ Allergy #3: _____

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REVIEWS OF SYSTEMS

Have you had any of these symptoms?

- ☐ Not applicable
- ☐ **EYE** Blurred Vision / Double Vision
- ☐ **ENT** Hearing Loss / Hoarseness / Swallowing difficulties
- ☐ **ENDO** Thyroid Disease / Thyroid Problems / Autoimmune Disorders
- ☐ **NEU** Headaches / Dizziness / Stroke
- ☐ **CV** High Blood Pressure / Palpitations / Congestive Heart Failure / Heart Attack / Pacemaker
- ☐ **RS** Chronic Cough / Shortness of Breath / Asthma / Sleep Apnea
- ☐ **GI** Heartburn / Ulcers / Liver Disease
- ☐ **GU** Painful Urination / Kidney Problems / Bladder Infections / Kidney Infections / Blood in Urine
- ☐ **HEM** Easy Bruising or Bleeding / Thrombosis or Embolisms (Clots) / Anemia
- ☐ **SK** Frequent Rashes / Psoriasis / Skin Ulcers
- ☐ **PS** Addiction / Depression / Alcohol Abuse / Drug Abuse

SOCIAL HISTORY

Do you smoke or chew tobacco?

- ☐ Yes - Please explain: _____
- ☐ No

Do you drink alcohol?

- ☐ Yes - Please explain: _____
- ☐ No

Do you use any street drugs?

- ☐ Yes - Please explain: _____
- ☐ No

FAMIL HISTORY

- ☐ Medical Issue #1: _____
- ☐ Medical Issue #2: _____
- ☐ Medical Issue #3: _____

PROCEDURE INFORMATION If Applicable:

Are you pregnant?

- ☐ Yes - Please explain: _____
- ☐ No

Are you diabetic?

- ☐ Yes - Please state treatment type (Diet/Oral Medications/Pump): _____
- ☐ No

Are you on blood thinners?

- ☐ Yes - Please explain: _____
- ☐ No

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Have you or a family member ever had a reaction to anesthesia?

☐ Yes - Please explain: _____

☐ No

What tests have you had for your current problem?

Diagnostic Imaging	When	Results
X-ray		
CT scan		
Bone Scan		
Ultrasound		
MRI		

Are there any specific questions you would like to discuss today?

1. _____
2. _____
3. _____

PLEASE SIGN:

I understand that this is a one-time diagnostic assessment. The information on these forms is accurate to the best of my knowledge.

SIGNATURE: _____

DATE: _____

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