THERAPY PLUS HEALTH SOLUTIONS INC

9711 Skokie Blvd. Suite F
Skokie IL, 60077
Ph. 773.282.4300

Patient Medical History

Personal Information

First Name: _____

Last Name: _____

DOB: _____/_____/_____ (MM/DD/YYYY)

Today's Date: _____/_____/_____ (MM/DD/YYYY)

Sex: _____

Chief Complaint

What is your reason for seeing us? _____

_____

Date of Injury / Onset of Symptoms: _____

Main Problem :
(Check all that apply)

☐ Pain ☐ Numbness ☐ Popping
☐ Unstable ☐ Weakness ☐ Grinding
☐ Stiffness ☐ Other: _____

Where did the injury/complaint occur:

☐ Work ☐ Home ☐ Sports/Recreation
☐ School ☐ Car Crash
☐ Other: _____

Severity/Intensity of pain:
(1: No pain; 10: Worst pain ever)

1 2 3 4 5 6 7 8 9 10

Quality of pain:

☐ Sharp ☐ Stabbing ☐ Aching ☐ Tingling
☐ Numb ☐ Dull ☐ Burning ☐ Radiating
☐ Throbbing ☐ Cramping

Previous/Current treatment for complaint: ☐ **None**
(Check all that apply)

Therapies: ☐ Chiropractic ☐ Physical Therapy ☐ Injections
☐ Other: _____

Medications: ☐ Pain Medication ☐ Muscle Relaxants ☐ Anti-inflammatory
☐ Other: _____

Imaging: ☐MRI ☐ CT Scan ☐ X-Ray
☐ Other: _____

Are you pregnant? ☐ Yes ☐ NO

Medical History

Do you have any of the following conditions: ☐ **None**
(Check all that apply)

☐ Abnormal Heart Rhythm
☐ Acid Reflux
☐Alcoholism/Drug Abuse
☐ Anxiety/Bipolar
☐ Asthma
☐ Bladder/Bowel Problems
☐ Bleeding Disorder
☐ Blood Clots
☐ Bronchitis
☐ Cancer: _____
☐ COPD
☐ Depression/Suicidal
☐ Goiter
☐ Gout
☐ Heart Attack
☐ Heart Disease
☐ Heart Failure
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Hypothyroidism
☐ Kidney Disease/Issues
☐ Metal Implants
☐ Migraines
☐ Osteoarthritis
☐ Osteoporosis
☐ Pacemaker
☐ Pneumonia
☐ Psoriatic Arthritis
☐ Reactive Arthritis
☐ Rheumatoid Arthritis
☐ Seizures
☐ Sexual Dysfunction
☐ Sleep Apnea
☐ Stomach Ulcers
☐ Stroke
☐ Other: _____

Review of Symptoms

Are you experiencing any of the following? *(Check all that apply)*

☐ Back pain
☐ Behavior change
☐ Bloody Stool
☐ Fainting
☐ Fatigue
☐ Fever
☐ Pain with urination
☐ Rashes
☐ Redness of skin

☐ Blood in urine
☐ Blurred vision
☐ Chest pain
☐ Chest palpitations
☐ Chills
☐ Change in appetite
☐ Constipation
☐ Cough
☐ Diarrhea
☐ Difficulty with balance
☐ Difficulty breathing
☐ Difficulty swallowing
☐ Dizziness
☐ Double vision
☐ Dry eyes
☐ Hair loss
☐ Hallucinations
☐ Headaches
☐ Heartburn
☐ Joint pain
☐ Lightheaded
☐ Loss of consciousness
☐ Loss of vision
☐ Memory loss
☐ Muscle weakness
☐ Nausea
☐ Neck pain
☐ Night sweats
☐ Nodules/Bumps on skin
☐ Numbness
☐ Shortness of breath
☐ Shoulder pain
☐ Stress
☐ Sleep disturbance
☐ Stomach pain
☐ Sweating
☐ Swollen: _____
☐ Tremors
☐ Temperature intolerance
☐ Urinary incontinence
☐ Vomiting
☐ Weakness
☐ Weight gain
☐ Weight loss
☐ **None apply**

Previous Surgeries

Have you had any previous surgeries? If so, please include date and type of surgery.

☐ **None**

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Medications

Please list any prescriptions, over-the-counter medication, vitamins, or supplements being taken.

☐ **None**

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Allergies

Do you have any allergies? If so, please include what type.

☐ **None**

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Family History

Please indicate if you have a family history of any of the following, and your relation to the person.
(Check all that apply)

- ☐ Arthritis: _____
- ☐ Asthma _____
- ☐ Cancer _____
- ☐ COPD _____
- ☐ Diabetes _____
- ☐ Heart Disease _____
- ☐ High Cholesterol _____
- ☐ Hypertension _____
- ☐ Kidney Disease _____
- ☐ Migraines _____
- ☐ Scoliosis _____
- ☐ Stroke _____
- ☐ Thyroid Disease _____

Social History

(Check all that apply)

Occupation: _____ ☐ Full Time ☐ Part Time ☐ Unemployed

Do you use tobacco products? If yes, how much do you smoke per day, and for how long?

- ☐ No
- ☐ Former Smoker. Packs per day: _____ Number of years: _____
- ☐ Current Smoker. Packs per day: _____ Number of years: _____

Do you consume alcoholic products?

- ☐ No
- ☐ Occasionally. Number of drinks per week: _____
- ☐ Daily. Number of drinks per week: _____

What is your marital status?

- ☐ Single
- ☐ Married
- ☐ Divorced

Do you exercise? If so, what types of activities, and how often?

- ☐ No
- ☐ Occasionally. Type of exercise: _____ How often: _____
- ☐ Daily. Type of exercise: _____ How often: _____

How much do you sleep each day on average? _____

_____ _____

Signature of patient, parent, or guardian Date