COMPREHENSIVE MEDICAL HISTORY / ANTECEDENTES MEDICOS

From the list below, please mark (√) all the problems that you have, or have had, and explain in the space to the right.
De la siguiente lista, marque (√) todos los problemas que tiene o ha tenido y explique cada de ellos en el espacio a la derecha.

		DISEASES	ENFERMEDADES
1.	☐	Major illnesses in blood relatives	Enfermedades importantes en familiares
2.	☐	Hospitalizations or operations	Hospitalizaciones u operaciones
3.	☐	Exposure to hazardous materials	Exposición a sustancias peligrosas
4.	☐	Do you smoke?	Usted fuma?
5.	☐	Do you drink alcohol?	Toma bebidas alcohólicas
6.	☐	Skin problems	Problemas en la piel
7.	☐	Recent weight loss or gain	Pérdida o ganancia de peso reciente
8.	☐	Weakness and/or fatigue	Debilidad y/o fatiga
9.	☐	Nervous conditions	Trastornos nerviosos
10.	☐	Frequent headaches	Dolores de cabeza frecuentes
11.	☐	Head injuries / problems	Lesiones / Problemas en la cabeza
12.	☐	Dizziness/Fainting	Mareos / Desmayos
13.	☐	Epilepsy / Seizures	Epilepsia / Convulsiones
14.	☐	Eye / Vision problems	Problemas de la vista o de los ojos
15.	☐	Ear injuries / problems	Lesiones / problemas en los oídos
16.	☐	Nose / Sinus problems	Sinusitis o problemas en la nariz
17.	☐	Dental / gum disease	Problemas en dientes o encías
18.	☐	Throat / Hoarseness problems	Ronquera o problemas de garganta
19.	☐	Chest injuries	Lesiones en el pecho
20.	☐	Lung / respiratory problems	Problemas pulmonares / respiratorios
21.	☐	Chest pain / Heart problems	Dolor en el pecho / Problemas del corazón
22.	☐	High blood pressure	Presión arterial (sanguinea) alta
23.	☐	Neck / Back problems	Problemas en el cuello ó espalda
24.	☐	Shoulder / arm / elbow problems	Problemas en hombros / brazos / codos
25.	☐	Forearm / wrist / hand problems	Problemas en antebrazos, muñecas o manos
26.	☐	Numbness / Tingling	Adormecimiento / Hormigueo
27.	☐	Abdominal injuries / problems	Lesiones / Problemas abdominales
28.	☐	Indigestion / constipation / diarrhea	Indigestión / constipación / diarrhea
29.	☐	Liver diseases	Enfermedades del hígado
30.	☐	Hernias	Hernias
31.	☐	Kidney / Urinary problems	Problemas urinarios y del riñón
32.	☐	Hip / thigh / knee problems	Problemas de caderas/ muslos/ rodillas
33.	☐	Leg / ankle / foot problems	Problemas de piernas / tobillos / pies
34.	☐	Other bone / joint problems	Otros problemas de huesos y articulaciones
35.	☐	Diabetes	Diabetes
36.	☐	Anemia / Blood Disorders	Anemia / Problemas en la sangre
37.	☐	Previous work injuries	Lesiones previas relacionadas con el trabajo
38.	☐	Current medications	Medicinas que toma actualmente

Female Patients Only **Pacientes Femeninos Solamente**

39. Last menstrual period Ultimo período menstrual _____

40. Are you pregnant? ¿Esta embarazada? ☐ Yes / Sí ☐ No / No

Explain (Explique)

_____

Patient Signature (Firma del Paciente)

PHYSICIAN COMMENTS ON PAST MEDICAL HISTORY:

_____

Physician Signature

PATIENT INFORMATION / INFORMACIÓN DEL PACIENTE

Employer (Patrón):_____ Date (Fecha):_____ SSN:_____

First Name (Nombre):_____ Middle Initial (Inicial):_____ Last Name (Apellido):_____

If this is your first visit, please fill the blanks included in this box. (Si esta es su primera visita, por favor llene los espacios incluidos en este recuadro)

Address (Dirección):_____ City (Ciudad):_____ Zip (C. Postal):_____

Home Phone (No. Telefono en casa):_____ Work Phone (No. Telefono en el trabajo):_____

Birthdate (Nacimiento):_____ Sex (Sexo):_____ Marital Status (Estado Civil):_____

Date of Injury (Fecha de lesión):_____ Time (Hora):_____ Last day worked (Ultimo día que trabajo):_____

Occupation (Ocupación):_____

Address where injury occurred (Lugar donde ocurrió la lesión):_____

Was your problem caused by something that happened at work? (¿Fue su problema causado por algo sucedido en su trabajo? ☐ Yes (Si) ☐ No (No)

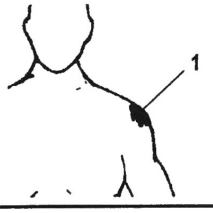
Injury was reported to (La lesion fue reportada a): _____ Date (Fecha):_____ Time (Hora): _____

Has U.S. HealthWorks ever treated you before? (Alguna vez ha sido tratado en U.S. HealthWorks?):_____ When? (Cuándo?):_____

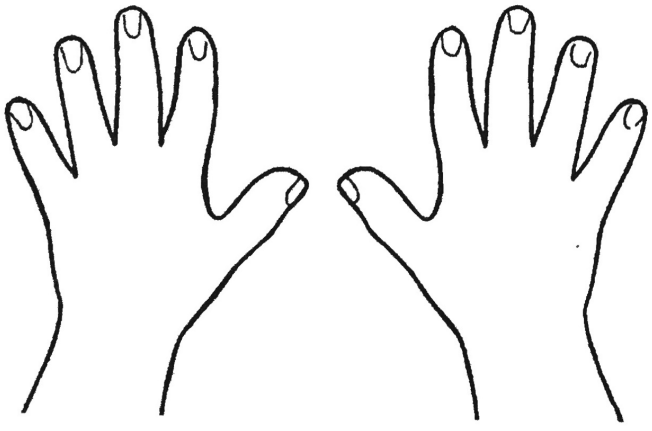
If this is your first visit, explain how your present injury/illness occurred. (Si esta no es su primera visita, explique cómo ocurrió su actual lesión ó enfermedad.)
If this is a follow up visit, indicate any improvement or changes in your condition. Si esta no es su primera visita, describa cualquier mejoria o cambio en su condición.

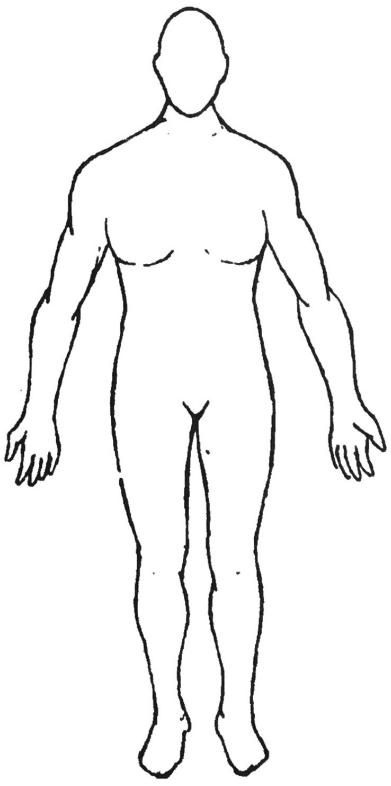
PLEASE COMPLETE THE FOLLOWING DIAGRAM *(Por favor complete el diagrama a continuación.)*

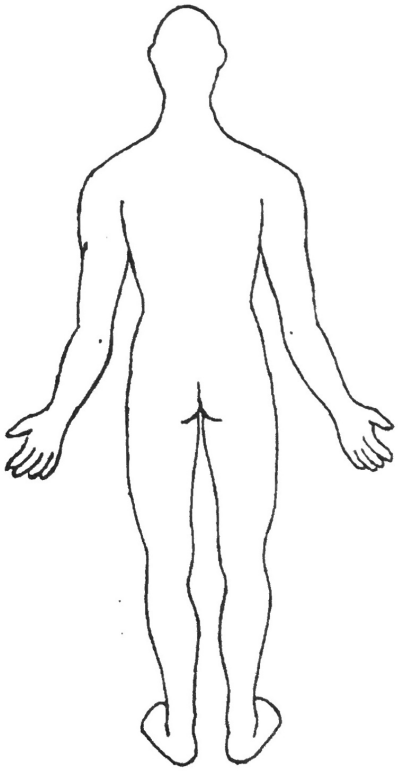
If you feel any of the symptoms below, mark the areas of the body where you feel them on the figures below and indicate the type of symptom.
(Si siente alguno de los síntomas listados a continuación, marque la zona del cuerpo en donde los siente en las figuras e indique el tipo de sintoma.

Symptoms (Síntomas):	Example (Ejemplo):
1. Pain (Dolor) 2. Numbness (Adormecimiento) 3. Burning (Quemazón) 4. Pins/Needles (Pinchazos)	

Rate the intensity of your pain: No Pain Most Pain
0 1 2 3 4 5 6 7 8 9 10
Indique la intensidad de su dolor Sin dolor Dolor intenso







Patient Signature *(Firma del Paciente)* _____ Date *(Fecha)* _____

PersonalBest
whole life warehouse

Patient's Name: _____ **Date:** _____

__ Soap Note __ New Symptom(s) __ Re-Examination __ Final Examination

Subject Complaints: _____

_____

The Patient Complaint(s) has: ___ Improved: __ Slight __ Better __ Great. __ No Change, __ Worsened, since last: _____ visit(s)

Headache:	L	R	Front	Occiput	Temporal	Min	Mild	Mod	Severe. w/ w/o:	Nausea	Vomiting	Dizziness
Neck:	L	R	Pain	Stiffness		Mild	Mod	Severe	Spasm	Reduced ROM		Parathesia
Thoracic Chest	L	R	Pain	Stiffness		Mild	Mod	Severe	Spasm	Reduced ROM		Parathesia
Lumbar Spine:	L	R	Pain	Stiffness		Mild	Mod	Severe	Spasm	Reduced ROM		Parathesia
Sacral Iliac Jt:	L	R	Pain	Stiffness		Mild	Mod	Severe	Spasm	Reduced ROM		Parathesia
Upper Extremity:	L	R	Pain	Stiffness		Mild	Mod	Severe	Spasm	Reduced ROM		Parathesia
Upper Shoulder:	L	R	Pain	Stiffness		Mild	Mod	Severe	Spasm	Reduced ROM		Parathesia
Lower Extremity:	L	R	Pain	Stiffness		Mild	Mod	Severe	Spasm	Reduced ROM		Parathesia

Other: _____: _____

Objective: Finding(s)/ Action: _____

_____

Palpable tenderness was present in the following regions with the following degree of intensity.
(1: Min, 2: Mild 3: Mild/Mod, 4: Mod, 5: Mod/Severe 6: Severe)
With without myospasm and other signs: _____

Cervical Spine:	L	R	Sub occipital	Cervical Para spinal (upper/mid/low)	SCM	Scalene	Other: _____
Chest/ Ribs:	L	R	Sternum	Ribs (Upper/Mid/Low)	Level(s)		
Thoratic Spine:	L	R	Rhomboids	Para spinal (upper/mid/low)	Trapezius (upper/Mid/Lower)		Levator Scapulae
Lumbar Spine:	L	R	Hamstring	Para spinal (upper/mid/low)	Psoas	Si Jts	Gluteal/ Pisiforms
Pelvic/ Hip:	L	R	Abdominal (Upper/ mid/ Lower quadrant)				
_____:	L	R	_____				

Active/ passive/ Resisted-Range of Motion (A/ P/ R/ ROM): ROM was evaluated with the following(s): Global Segmental Both
(Level of Restriction: 0: Normal, 1: Minimal-5*, 2: Mild 10-15*, 3: Mild/Mod 20-30*, 4: Moderate 30-40*, 5: Mod/Severe 40-50*, 6: Too Severe, Cannot Preform)
Cervical Spine: L R_____, Thoracic Spine: L R_____, Lumbar Spine: L R_____, U/L Extremity: L R_____

Segmental Dysfunction(s) (S/D) were detected in the following regions:
C0, C1, C2, C3, C4, C5, C6, C7, T1, T2, T3, T4, T5, T6, T7, T8, T9, T10, T11, T12, L1, L2, L3, L4, L5, S1, S2, S3, S4, L/R: SI Jts.
L/R: Shoulder Elbow Wrist Hip Knee Ankle (UE/LE) Phalanges L/R: _____ Rib(s)

Assessment:

See initial Physical Exam: _____
Patient is: Improved Unchanged Worsen: _____
Diagnosis is: Unchanged Changed Added: _____

Treatment Plan/ Recommendations(s)

Based upon patient's presenting complaint(s), objective finding(s) , and clinical assessment(s): Following procedure(s)/ care(s) are implemented:
___ Chiropractic Manipulation Therapy Manipulation: ___1-2 Region (98940), ___3-4 Region (98941), ___UE/LE (Extremity) (98943)
___ Manual Therapy Technique (MT), ___Myofascial Release Therapy (MRT) ___Therapeutic Kinetic Exercise/ Activity
___ Neuromuscular Re-education, ___Gait Training ___Therapeutic Massage
___ Therapeutic Modalities: Hot/ Cold Therapy ___Mechanical Traction ___E.M.S/ I.F ___Ultrasound ___Infrared ___ Laser
___ Home Instructions: ___Ice/Hot (15 min), ___ Spine Support, ___ Self ADL, ___ Personal Exercise Care Program: ___C/S ___L/S ___ UE ___LE

The Following Recommendation(s) is/ are made regard to the ongoing or final clinical management to the patient named above:
___ Referral for diagnostic study(s) ___ Referral for further evaluation: _____
___ Continued Care, ___ Modify Care ___ Discharged: ___ With/Without Homecare exercise(s): _____

Comments: _____

_____

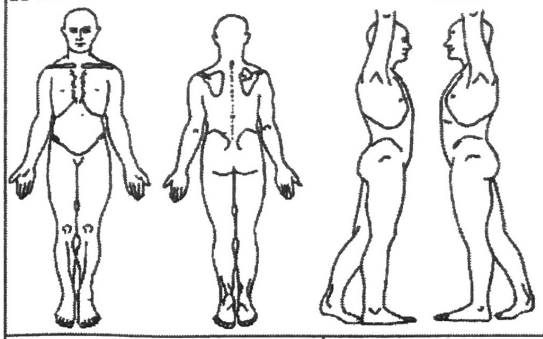
Signed By: (Please Print Doctor's Name): _____ Dr's Signature: _____

NAME: _____

COUNTRY: _____

Chief Complaint:	Date:
	Event:
DIAGNOSIS:	

LOCATION **Location Notes**



ONSET	Aggravating Factors
Quality	Easing Factors
Severity: /10	

SIGNIFICANT ORTHOPEDIC TESTING:

MUSCULAR ADHESIONS/TENDERNESS/SPASMS/WEAKNESS

Muscle	Cervical Paraspinals	R L B	Lower Extremity	R L B
	Thoracic Paraspinals	R L B	GH & Periscapular	R L B
	Lumbar Paraspinals	R L B	Upper Extremity	R L B
	FA Complex	R L B	Periscapular	R L B

Specific Muscle Involvement:

Joint Mobility	Upper cervical	R L B	Shoulder/Scap	R L B
	Cervical	R L B	Elbow	R L B
	C/T Junction	R L B	Wrist	R L B
	T/S	R L B	Hand/Finger	R L B
	Rib	R L B	Hip	R L B
	Thoracolumbar	R L B	Knee	R L B
	L/S	R L B	Ankle	R L B
	Lumbopelvic	R L B	Foot/Toe	R L B

Notes on Joint Involvement: Hypermob Hypomob Dyskinesis

IMPRESSION/DIAGNOSIS:

TREATMENT PROVIDED:		TREATMENT OUTCOME:		PLAN:
Soft Tissue Manipulation	Supportive Taping	IMPROVEMENT	NC	PRN
Massage/Flush	Ridged Taping	MILD		ORTHO
Graston	Kinesiology tape	MODERATE		MD
Active Muscle Release	Cryotherapy	MARKED		ER
Passive Muscle Release	Stretch Active	DURATION 15 30 45 60		
Joint Manipulation	Stretch Passive			
Ther Ex	PNF			
Muscle Energy	Other:			

OTHER NOTES:

Practitioner:

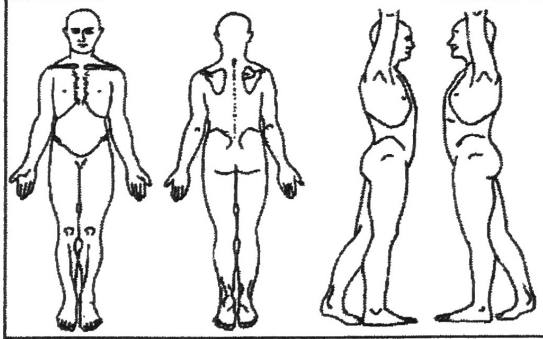
SPORTS MEDICINE

NAME: _____

COUNTRY: _____

Chief Complaint:	Date:
	Event:
DIAGNOSIS:	

LOCATION **Location Notes**



ONSET	Aggravating Factors
Quality	Easing Factors
Severity: /10	

SIGNIFICANT ORTHOPEDIC TESTING:

MUSCULAR ADHESIONS/TENDERNESS/SPASMS/WEAKNESS

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	FA Complex	R L B	Periscapular	R L B

Specific Muscle Involvement:

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	C/T Junction	R L B	Wrist	R L B
	T/S	R L B	Hand/Finger	R L B
	Rib	R L B	Hip	R L B
	Thoracolumbar	R L B	Knee	R L B
	L/S	R L B	Ankle	R L B
	Lumbopelvic	R L B	Foot/Toe	R L B

Notes on Joint Involvement: Hypermob Hypomob Dyskinesis

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Graston	Kinesiology tape	MODERATE		MD
Active Muscle Release	Cryotherapy	MARKED		ER
Passive Muscle Release	Stretch Active	DURATION 15 30 45 60		
Joint Manipulation	Stretch Passive			
Ther Ex	PNF			
Muscle Energy	Other:			

OTHER NOTES:

Practitioner:

SPORTS MEDICINE

Patient Name *(print)*_____ Date _____

Patient Comments:

1. Since my last appointment, my condition is:

☐ Unchanged ☐ Improved ☐ Worsened

☐ Got better then worse ☐ Different

2. My present level of pain on a scale of 0 - 10:

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (extreme pain)

3. My area of pain/discomfort today is:

☐ Head/Neck ☐ Upper Back ☐ Middle Back

☐ Lower Back ☐ Shoulders ☐ Arms/Elbows

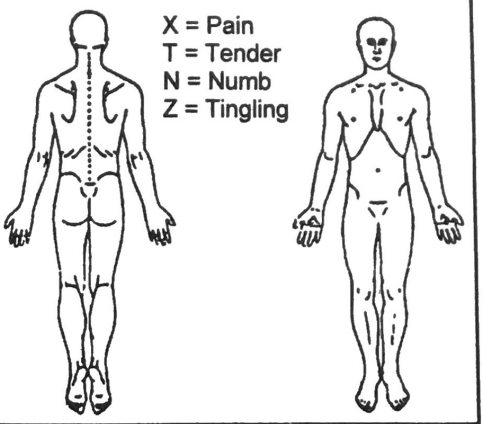
☐ Wrists/Hands ☐ Hips/Legs/knees ☐ Feet/Ankle

4. Since my last appointment: ☐ I have ☐ I have not had a new injury/problem. Explain:_____

_____

Please Draw a Picture of Your Discomfort

X = Pain
T = Tender
N = Numb
Z = Tingling



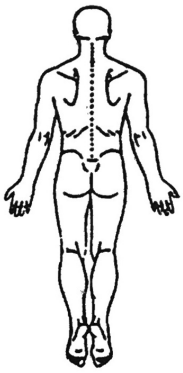
Signature

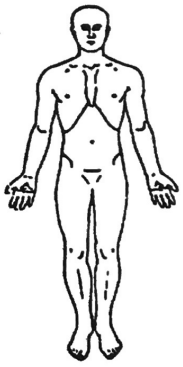
_____

(For office use only: Do not write below this line)

Notes

Pain: 1 2 3 4 5 6 7 8 9 10
Tenderness: 1 2 3 4 5
Spasm: 1 2 3 4 5
Inflammation:
Weakness:
Paresthesia
N / T / B
Posture:
Meds: PK / AI / MR





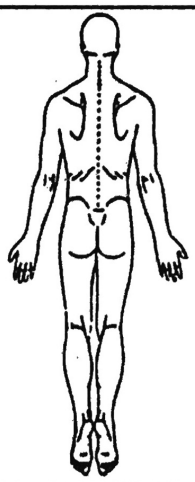
Trigger Points
Restrictions
ROM:

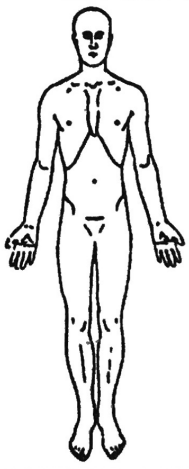
Activity:

TMJ/Occiput
C 1 2 3 4 5 6 7
T 1 2 3 4 5 6
7 8 9 10 11 12
L 1 2 3 4 5
L-S
SI
Other _____

_____

Ultrasound
EMS
Muscle Therapy
Heat/Ice
C/S Traction
Manipulation
Taught Exercise
C / T / L / Extrem
Taught Stretch





Comments

Orthos: WNL / NC / Res
Neuro: WNL / NC / Res
Dx: UC / Res
A / SA / Ch / R
Relief on Exit : none / s / m / ex
See ___ X wk / mon / prn

Key: N=numbness; T=tingling; B=burning; MR=muscle relaxants; AI= anti-inflammatories; PK=painkiller; EMS=elect. Muscle stim; Int=interferential; D=Diversified; MRT= manual release technique; Mob=mobilization; C=cervical; LB=low back; Ab=abdominal; Sh=shoulder; NC=no change; Res=resolving; UC=unchanged; A=acute; SA=sub-acute; Ch=chronic; R=recurrent; s=slight; m=moderate; ex=excellent