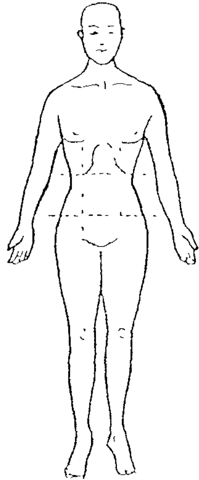
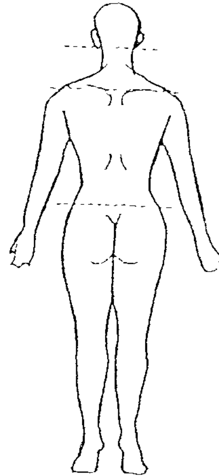
Vis Clinic Chiropractic/Physical Medicine Musculoskeletal History Form

Name: ____ **Date:** _______________

Onset of problem (Date): ____
Chief Complaint (Musculoskeletal): ____
____
____
____
Location of pain or problem area: ____

Mark an "X" on the picture where you currently experience pain or numbness.





What **Diagnosis** has been given for your complaint? _____________________________________
Have you had **Diagnostic Imaging** for your current complaint? □ Yes □ No Explain: _______________
____
What positions or activities **increase your pain**? □ Forward bending □ Backward bending □ Side bending
□ Sleeping □ Sitting □ Standing □ Other ____
What position or activity **decreases your pain**? □ Forward bending □ Backward bending □ Side bending
□ Sleeping □ Sitting □ Standing □ Other ____
Which of the following **help your pain** or problem? □ Heat □ Ice □ Rest □ Movement □ Stretching
□ Pain Medicine (________________________) □ Other ________________________________
What word best describes the **type of pain** you are experiencing? □ Sharp □ Dull □ Achy □ Burning □ Stabbing
□ Pins and Needles □ other ____
Do you currently experience **radiating pain**? location:__________________________________
What **time of day** is your pain or condition the worst? □ Morning □ Midday □ Night □ Other: _____________
Please rate your current **pain intensity** level (0 = no pain; 10 = worst pain imaginable) 0 1 2 3 4 5 6 7 8 9 10
Do you have **metal implants, joint replacements or a pacemaker device**? Explain: _______________
____
Do you experience **decreased sensation** over any areas of your body? ___________________________
How has your condition affected your activities of daily living? _____________________________
____
What **treatment** have you received for your condition? □ Medication(s) □ Surgery □ Physical Therapy
□ Acupuncture □ Massage □ Chiropractic Services □ other Explain: ____________________________
____
Name of **other Doctor(s) / therapist(s)** who have treated you for your condition?

Vis Clinic Chiropractic/Physical Medicine Musculoskeletal History Form

Outpatient Procedures/ Surgeries:

Type (of surgery):	Date:	Reason for Procedure/Admission:	Outcome/Results:
Tonsils			
Ear Tubes			
Appendectomy			
Hysterectomy			
Hernia			
Gallbladder			
Heart Bypass			
Orthopedic			
Cancer (Region)			
Other:			

Major Illnesses/ Injuries –Accidents/Hospitalizations:

Type:	Date:	Treatment Received:	Outcome:
Head Injury			
Neck Injury			
Back/Spine Injury			
Extremity Injury			
Broken bone(s)			
Infections			
Other:			

Medications: (prescription and over the counter that you are NOW taking):

Name of Drug	Reason for Taking	Dose (mg/etc)	For How Long	Prescribing Dr.

Vis Clinic Chiropractic/Physical Medicine Musculoskeletal History Form

Chiropractic Manipulation Screening Questionnaire

Please check if you have had or currently have any of the following conditions or imaging and whether you have ever taken any of the medications listed.

______HIV Positive
______Osteoporosis or Osteopenia
______Avascular Necrosis
______Fracture of spine or other bones
______Cancer metastasis
______Carotid bruits/narrowing
______Physical inactivity
______Malnutrition
______Smoking
______Hypogonadism
______Prolonged bed rest
______Chronic illness
______Severe weight loss
______Hyperthyroidism
______Parathyroid axis disruption
______Malabsorption
______Multiple Sclerosis
______Bleeding disorders
______Rheumatoid Arthritis
______Psoriatic Arthritis
______Reiter's Syndrome
______Ankylosing Spondylitis
______Vertebral Infection

Medication use	**Month/Year**
______ Corticosteroids	_________
______ Phenobarbitol	_________
______ Pentamidine	_________
______ Ketoconazole	_________
______ Protease inhibitors	_________
______ Anticoagulants	_________

Abnormal Imaging History Results	**Month/Year**
______ Dexa/bone scan	_________
______ MRI/CT	_________
______ X-ray	_________

Name of Family Doctor: ____________________________ Date Last Seen ___________________________

Whom may we thank for referring you? ____