SporTherapy Patient Medical History Form

Patient Name: _____
Preferred Name: _____
DOB: _____ / _____ / _____

Have you experienced any of the following symptoms in the past 3 months:

Abdominal pain	❑ Yes ❑ No	Dizziness or fainting	❑ Yes ❑ No	Rashes or skin changes	❑ Yes ❑ No
Chest pain	❑ Yes ❑ No	Fatigue	❑ Yes ❑ No	Shortness of breath	❑ Yes ❑ No
Constant night pain	❑ Yes ❑ No	Headache	❑ Yes ❑ No	Swelling in hands or feet	❑ Yes ❑ No
Diarrhea or constipation	❑ Yes ❑ No	Numbness/tingles	❑ Yes ❑ No	Vision or hearing changes	❑ Yes ❑ No
Decreased balance	❑ Yes ❑ No	Unexpected weight change	❑ Yes ❑ No		

	Not at all	Several days	More than half the days	Nearly every day
Over the last 2 weeks, have you felt down, depressed, or hopeless?	0	1	2	3
Over the last 2 weeks, have you felt little interest or pleasure in doing things?	0	1	2	3

Is this something with which you would like help for today/now? ❑ Yes ❑ No ❑ Yes, but not today

Have you EVER been diagnosed with any of the following:

Anemia	❑ Yes ❑ No	Fibromyalgia	❑ Yes ❑ No	Stroke	❑ Yes ❑ No
Arthritis; type: _____	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Thyroid dysfunction	❑ Yes ❑ No
Alzheimer's/dementia	❑ Yes ❑ No	High blood pressure	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	History of infection	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Blood clots	❑ Yes ❑ No	Joint replacement	❑ Yes ❑ No	Urinary tract infection	❑ Yes ❑ No
Cancer; type: _____	❑ Yes ❑ No	Kidney condition	❑ Yes ❑ No	Vertigo	❑ Yes ❑ No
COPD	❑ Yes ❑ No	Multiple sclerosis	❑ Yes ❑ No	Vision loss	❑ Yes ❑ No
Depression	❑ Yes ❑ No	Osteoporosis/ -penia	❑ Yes ❑ No	Heart attack / heart surgery	❑ Yes ❑ No
Diabetes; type: _____	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No	Heart condition; type:_____	❑ Yes ❑ No
Drug or alcohol abuse	❑ Yes ❑ No	Parkinson's	❑ Yes ❑ No	Difficulty starting or stopping urination	❑ Yes ❑ No
Epilepsy	❑ Yes ❑ No	Pneumonia	❑ Yes ❑ No		

If you have been diagnosed with a condition not listed, please report here: _____

Current Medications:

_____
_____
_____
_____
_____
_____

Past surgeries (month/year)

_____
_____
_____
_____
_____
_____

Have you ever taken steroid medications for any medical conditions? ❑ No ❑ Yes; How long, often? _____

Allergies:

Do you have allergies to medications? If yes, please list: _____

Other allergies (latex, bees, etc.) _____

CURRENT SYMPTOMS:

When and how did your present symptoms start? _____

My symptoms are: ❑ Getting Better ❑ Getting Worse ❑ Staying the same

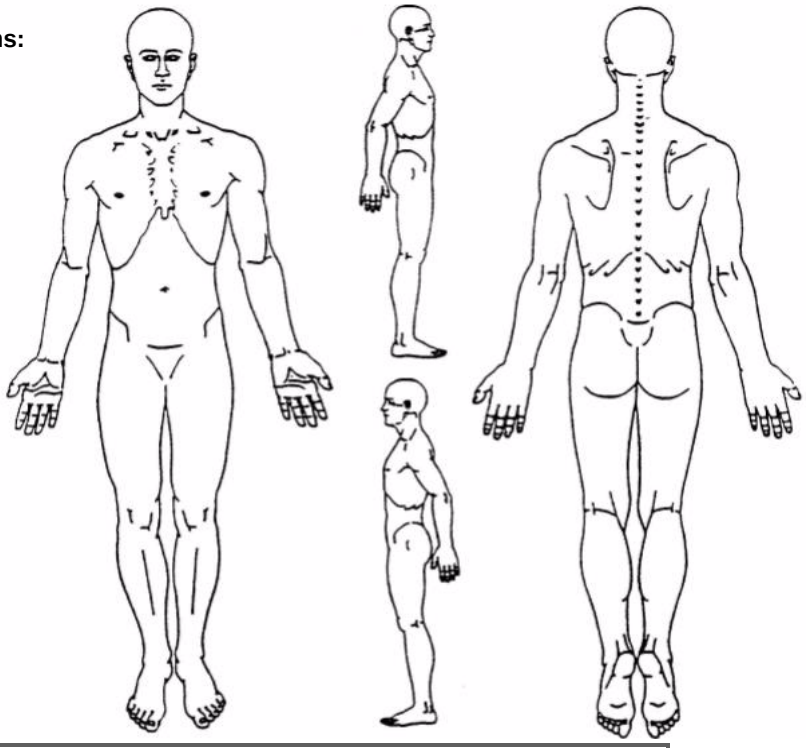
Treatment received so far for this problem (chiropractic, injections, etc): _____

Please list any imaging received for current symptoms if applicable (MRI, x-ray, etc.): _____

Have you ever had this problem before: ❑ Yes ❑ No When: _____

Body Chart:

Please mark the chart with an "X" where you feel symptoms:



Do you ever experience numbness or tingling:
❑ Yes ❑ No

My symptoms currently:
❑ Come and go
❑ Are Constant
❑ Are constant, but change with activity

Pain levels: 0 being "no pain" and 10 being the "worst pain imaginable" please describe:

Current level of pain: _____/10

Best your pain has been during the past week: _____/10

Worst your pain has been during the past week: _____/10

Physical Well-being:

Please list any activities in which you are physically active (gardening, yard work, running, lifting, etc.): _____

How has sleep been impacted due to your symptoms? _____

How many hours of sleep do you usually get each night? _____

Do you have any lifting or work restrictions? ❑ Yes ❑ No

Have you had any falls in the past 6 months? ❑ Yes ❑ No

Do you feel knowledgeable about your nutritional needs? ❑ Yes ❑ No

Do you have or ever had a problem with weight or eating? ❑ Yes ❑ No

Do you currently smoke or use tobacco? ❑ Yes ❑ No ❑ Quit smoking

Rate the amount of stress in your life: ❑ None ❑ A Little Bit ❑ Moderate ❑ Quite a Lot ❑ Extreme

How well do you manage stress? ❑ Not at all ❑ A Little Bit ❑ Moderate ❑ Quite well ❑ Excellent

FOR WOMEN:

Are you currently pregnant or think you might be pregnant? ❑ Yes ❑ No

Do you get a regular menstrual cycle? ❑ Yes ❑ No