VPTR – CURRENT CONDITION/MEDICAL HISTORY QUESTIONNAIRE

Patient Name: ____________________________________ **Date:** ______/______/______

DOB:_______ Age: ______ Weight: ______ Height: ______ Gender: ❑Male ❑Female

Description of problem (i.e. body part, cause, etc.) ____

____

Date problem began:____________ Have you ever had this problem before? ❑ YES ❑ NO If yes, when? ___________________

Are your symptoms: ❑ Getting worse ❑ Staying the same ❑ Getting better

Is this injury related to (Check one if applicable): ❑ Work ❑ Automobile Accident

Occupation: ___________________________ Years at current job: _____ Are you on work restrictions per physician? YES NO

Have you had Chiropractic treatments? ❑YES ❑NO If yes, when was your last visit? _______ # of visits___

Have you received Physical/Occupational Therapy? ❑ YES ❑ NO If yes, when? ______ Where? ______________________________

Are you currently receiving any HOME HEALTH services? ❑ YES ❑ NO (Home Health must be terminated before OUTPATIENT PT/OT begins)

Have you had any of the following tests for your current condition? ❑ X-ray(s) ❑ MRI ❑ Bone scan ❑ CT scan ❑ Other (List):___________

Do you have a pacemaker? ❑ Yes ❑ No Are you currently pregnant? ❑ Yes ❑ No ❑ N/A Are you stressed? ❑ Yes ❑ No

Do you use tobacco (snuff/smoking)? ❑ Yes ❑ No If yes, # of packs/day _____, # of years ______ Last tobacco use ________

How frequently do you use alcohol? ❑ Never ❑ Occasionally ❑ Frequently

How frequently do you use illicit drugs (cocaine, marijuana, etc.)? ❑ Never ❑ Occasionally ❑ Frequently

How would you rate your current state of health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

PSYCHOLOGICAL

During the past month, have you experienced: ❑ Feeling down ❑ Depressed ❑ Hopeless ❑ Little interest/pleasure in things?

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ❑ Yes ❑ No

Is this something you would like help? ❑ Yes ❑ Yes, but not today ❑ No

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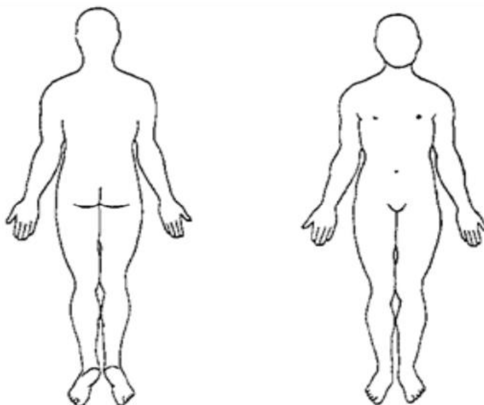
Body Chart: Please use the following symbols to describe your symptoms by marking the areas on the chart below.

/// **Shooting/sharp pain**
000 **Dull/aching pain**
↓ **Numbness**
= = **Tingling**
xxx **Burning**



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

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1.____________________________ 2.____________________________ 3.____________________________

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1.____________________________ 2.____________________________ 3.____________________________

How are you currently able to sleep at night due to your symptoms?

❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst?

❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

When are your symptoms the best?

❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

Using the 0 to 10 pain scale, with 0 being "no pain" and 10 being "worst pain imaginable/excruciating", please describe your pain:

CURRENT: ______ PAST 24 HOURS: BEST____ WORST_________

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Patient Name: ___________________________________ **Date:** ______/______/______

Please list ALL surgical procedures you have had in the past:

Surgery: ______________________________ Date: _________ Surgery: ______________________________ Date: __________
Surgery: ______________________________ Date: _________ Surgery: ______________________________ Date: __________
Surgery: ______________________________ Date: _________ Surgery:_______________________________ Date: __________

Have YOU had or are being treated for (check all that apply):

- ❑ Cancer
- ❑ Pacemaker
- ❑ Heart Attack
- ❑ Angina/Chest pain
- ❑ Congestive Heart Failure
- ❑ Stroke
- ❑ Blood clots
- ❑ Anemia
- ❑ High blood pressure
- ❑ Diabetes
- ❑ Thyroid disease
- ❑ Emphysema/COPD
- ❑ Asthma
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Seizures/Epilepsy
- ❑ Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Osteoporosis
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Lupus
- ❑ Hepatitis
- ❑ Sexually transmitted disease/HIV
- ❑ GI problems/bleeding
- ❑ Ulcers/Stomach problems
- ❑ Headaches
- ❑ Bone or Joint infection
- ❑ Eye problem/infection
- ❑ Chemical dependency (i.e. alcoholism/drugs)
- ❑ Other: ________________

Has anyone in your immediate FAMILY (parents, brothers, sisters) EVER been diagnosed with (check all that apply):

- ❑ Cancer
- ❑ Heart disease
- ❑ High blood pressure
- ❑ Diabetes
- ❑ Stroke
- ❑ Depression
- ❑ Tuberculosis
- ❑ Thyroid disease
- ❑ Blood clots

In the past 3 months have you had or are experiencing (check all that apply):

- ❑ Change in your health
- ❑ Dizziness/vertigo/balance problems
- ❑ Unexplained weight gain/loss
- ❑ Changes in bladder function
- ❑ Hearing/visual disturbances
- ❑ Fever/chills/sweats
- ❑ Difficulty swallowing
- ❑ Urinary tract infection
- ❑ Changes in appetite
- ❑ Upper respiratory infection
- ❑ Numbness/tingling
- ❑ Shortness of breath
- ❑ Nausea/vomiting
- ❑ Changes in bowel
- ❑ Difficulty sleeping

Please list any MEDICATIONS you are currently taking (include pills, injections, and/or skin patches):

❑ Please see attached list

____
____
____

Allergies (Please include all):

____
____

____ ____________

Signature (THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE) DATE