EASTERN IDAHO SPINE • SPORTS AND REHAB CENTER
an affiliate of Mountain View Hospital

**SARAH VLACH, MD • TYLER HEDIN, MD**

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**CRAIG KANTACK, PA-C • K'LYNDA SNARR, PA-C**

**LINDSAY VENN, PA-C**

*BOARD CERTIFIED, PHYSICAL MEDICINE & REHABILITATION*

| Name: | Birthdate: |
|---|---|
| Height: | Weight: |

| **Chief Complaint:** What is the reason for your appointment? (please describe why you are here) |
|---|
| |

| **Medications:** Please list **ALL** medications with dosages you are currently taking, including vitamins, herbs and supplements: *IF YOU HAVE A MEDICATION LIST PLEASE ATTATCH.* |
|---|
| ☐ I take no medications or supplements: |
| ☐ I take a blood thinner (Such as Coumadin or Plavix) **Prescribing provider:**<br>☐ **I have a Pacemaker/defibrillator or medical implant. (PLEASE PROVIDE CARD)** |

| **Past Medical History:** Please list ALL of your medical conditions for which you see a doctor: |
|---|
| ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Unknown<br>☐ Other: |

| **Allergies:** Please list **ALL** of your allergies to medications |
|---|
| ☐ No known drug allergies ☐ Iodine ☐ Sulfa ☐ Other: |

| **Surgical History:** Please list all inpatient and outpatient surgeries you have had. *IF YOU DO NOT HAVE ENOUGH ROOM PLEASE TURN PAPER OVER AND WRITE ON THE BACK.* | |
|---|---|
| Date(s): | Surgeries: |

| **Hospitalizations:** Please list dates and reason(s) you were hospitalized overnight. | |
|---|---|
| Date(s): | Reason: |

| **Family History** | |
|---|---|
| **Father** | **Mother** |
| ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke ☐ Mental Illness ☐ Cancer ☐ Unknown<br>☐ Other: | ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Stroke<br>☐ Mental Illness ☐ Cancer ☐ Unknown<br>☐ Other: |

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| **Social History** |
|---|
| **Marital Status:** □ Single □ Married □ Divorced □ Widowed |
| **Work:** □ Employed □ Retired □ Disabled □ Not currently working |
| **Alcohol:** Do you drink alcohol? □ No □ Occasionally □ Rarely □ Frequently |
| **Drugs:** Do you currently use illicit or illegal street drugs? □ No □ Occasionally □ Rarely □ Frequently |
| **Tobacco:** Are you a: □ current smoker □ former smoker (when did you quit _____?) □ never smoker<br>If you smoke, how often: □ every day □ some days, but not every day<br>How soon after you wake up do you smoke? □Within 5 minutes □6-30 minutes □31-60 minutes □after 1 hour<br>How many cigarettes a day do you smoke? □ 5 or less □ 6-10 □ 11-20 □ 21-30 □ 31 or more<br>Are you interested in quitting? □ Yes □ No □ Thinking about it |

## Current Symptoms:

| What is your primary concern?<br>□ Pain □ Numbness<br>□ Weakness □ Other:<br>_____ | **Location:** Where are your symptoms? | **Onset:** How long have you had your symptoms? |
|---|---|---|

| **Inciting Event:** Was there anything specific that brought on the symptoms? Check any that apply. |
|---|
| □ Nothing specific, came on gradually<br>□ Motor vehicle accident/Date of accident (please describe)<br>□ Trauma (please describe)<br>□ Work-related incident/Date of incident (please describe)<br>□ Other (please describe) |

| **Course:** Overall, my symptoms are: |
|---|
| □ Much better □ A little better □ Staying about the same □ A little bit worse □ Much worse |

| **Aggravating Factors:** What makes your symptoms WORSE | **Alleviating Factors:** What makes your symptoms BETTER |
|---|---|
| □ Standing<br>□ Sitting<br>□ Walking<br>□ Bending Forward<br>□ Bending Backward<br>□ Lying down<br>□ Coughing/Sneezing<br>□ Other (please describe): | □ Standing<br>□ Sitting<br>□ Walking<br>□ Bending Forward<br>□ Bending Backward<br>□ Lying down<br>□ Other (please describe): |

| **Associated Symptoms:** | |
|---|---|
| Are you having TINGLING? □ Yes □ No | Are you having NUMBNESS? □ Yes □ No |
| Are you having WEAKNESS? □ Yes □ No | Are you having PAIN? □ Yes □ No |
| Are you having INCONTINENCE? □ Yes □ No | Are you having PINS AND NEEDLES? □ Yes □ No |

| **Therapy:** Who have you worked with *RELATING TO THIS ISSUE*? |
|---|

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| | |
|---|---|
| ☐ None<br><br>☐ Chiropractor: _____ | ☐ Physical Therapist: _____<br>(last attended): _____<br><br>☐ Other: _____ |

| **Injections:** | |
|---|---|
| ☐ None<br>☐ Trigger point injections ☐ Helpful ☐ Not Helpful<br>☐ Facet injections ☐ Helpful ☐ Not Helpful | ☐ Epidural steroid injections ☐ Helpful ☐ Not Helpful<br>☐ Other: _____ ☐ Helpful ☐ Not Helpful |

**Medications:** What medications have you used *RELATING TO THIS ISSUE*? Please check if it was helpful or not

☐ Muscle relaxants: ☐ Flexeril ☐ Skelaxin ☐ Other: _____ ☐ Helpful ☐ Not helpful
☐ Narcotics: ☐ Lortab ☐ Hydrocodone ☐ Oxycodone ☐ Other: _____ ☐ Helpful ☐ Not helpful
☐ Gabapentin/Neurontin ☐ Lyrica ☐ Cymbalta ☐ Other: _____ ☐ Helpful ☐ Not helpful
☐ NSAID: ☐ Ibuprofen ☐ Meloxicam ☐ Naproxen ☐ Other: _____ ☐ Helpful ☐ Not helpful

| **Diagnostic Tests:** What tests have you had *RELATING TO THIS ISSUE?* | | |
|---|---|---|
| ☐ None | Please list **WHEN** they were done | Please list **WHERE** they were done |
| ☐ X-Ray | | |
| ☐ MRI | | |
| ☐ CT Scan | | |
| ☐ Nerve Conduction Study or EMG | | |
| ☐ Acupuncture | | |
| ☐ Other: _____ | | |

| **Osteoporosis Screening** | **YES** | **NO** |
|---|---|---|
| Have you received a DEXA (bone density) to test for osteoporosis? | | |
| Have you ever been diagnosed with osteoporosis? | | |
| Is your osteoporosis currently being managed by a physician? | | |

| **Fall Risk Assessment** | **YES** | **NO** |
|---|---|---|
| Have you had a fall within the past 12 months? | | |
| Have you fallen multiple times in the past 12 months? | | |
| Did any of those falls result in injury? | | |
| Do you use any assistive devices? If yes, please circle one Wheel chair Walker Cane | | |
| Are you experiencing any difficulties with walking or balance? | | |
| Are you experiencing vision problems? | | |
| Are you experiencing medication side effects? | | |

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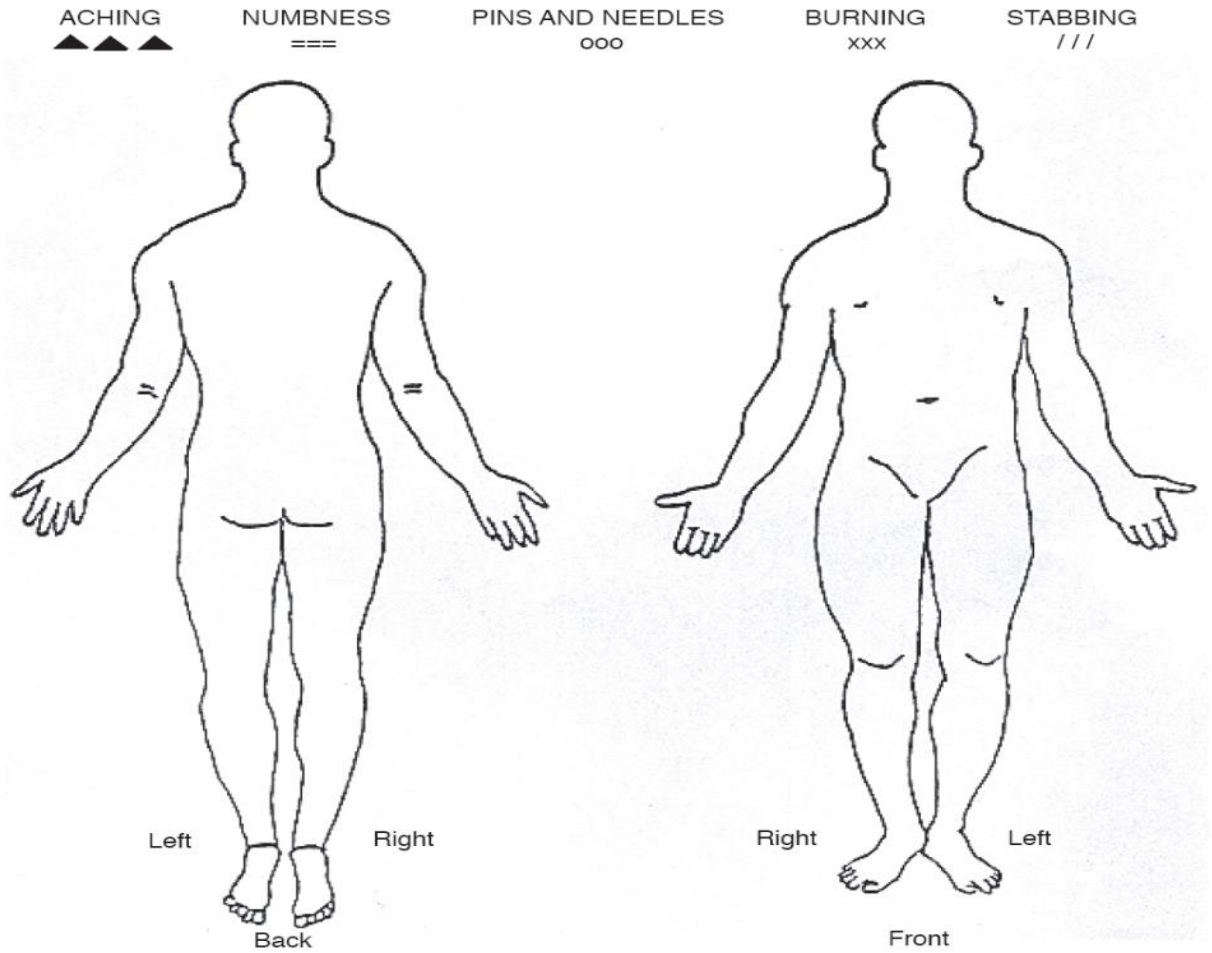
**Mark the areas on your body where you feel any of the sensations described below, using the appropriate symbol.** Include all affected areas. Please try to be specific about exactly which fingers or toes are involved.



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**Review of Systems:** Please check the boxes for any of the following symptoms you are experiencing **TODAY.**

**Constitutional:** ☐Fever ☐Unexplained weight loss ☐Chills ☐Other : _____

**Eyes:** ☐Blurry Vision ☐Swelling ☐ Double Vision ☐Other : _____

**Ears, Nose, Mouth, Throat:** ☐Ringing in ears ☐Sore Throat ☐Cough ☐Other : _____

**Cardiovascular:** ☐Chest pain ☐Other : _____

**Respiratory:** ☐Wheezes ☐Cough ☐Other : _____

**Gastrointestinal:** ☐Abdominal Pain ☐Nausea ☐Loss of control of bowels ☐Other : _____

**Genitourinary:** ☐Frequency ☐Loss of control of bladder ☐Other : _____

**Musculoskeletal:** ☐Decreased range of motion ☐Swelling ☐Pain ☐Other : _____

**Integumentary:** ☐Rashes ☐Skin breakdown ☐Other : _____

**Neurological:** ☐Weakness ☐Numbness ☐Headaches ☐Other : _____

**Psychiatric:** ☐Depression ☐Anxiety ☐Confusion ☐Other : _____

**Endocrine:** ☐Cold Intolerance ☐Excessive Thirst ☐Fatigue ☐Other : _____

**Hematologic/Lymphatic:** ☐Easy Bruising ☐Easy Bleeding ☐Swollen glands ☐Other : _____

**Allergic/Immunologic:** ☐Sneezing ☐Hives ☐Itchy Eyes ☐Other : _____

Please circle a number below to indicate how bad your pain is RIGHT NOW

None _____ Worst

0 1 2 3 4 5 6 7 8 9 10