

Electrodiagnostic Testing (NCS/EMG) PM&R Medical History Intake Form

Age _____ Date ____/____/____

Name _____

Referred By: _____

Handedness: Right / Left

What problem brings you here today? _____

How and when did it start? _____

What makes it worse? _____

What makes it better? _____

What do you want to accomplish from today's visit? _____

What treatments have you had?
(Physical Therapy, Chiropractic, Massage, Injections)

What diagnostic tests have you had for this problem?
(X-ray, EMG, MRI, Bone scan, etc)

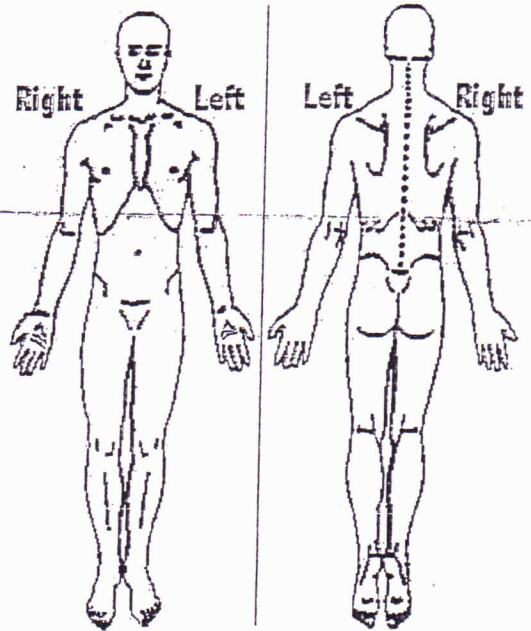
Please make a mark on the line below to indicate the level of discomfort you have today. Example: 4 / 5
 No Pain _____ Worst Pain Ever
 0 1 2 3 4 5 6 7 8 9 10

Please describe what the pain feels like: (Dull, Achy, Burning, Stabbing, Numbness, Tingling, Pulling, Cramping, Tightness)

Medications:

Please list ALL medications including Prescription, Over-the-Counter, Supplements/Vitamins

Please draw the location of your discomfort



Medical/Surgical History:

(All Surgeries, Broken Bones, Accidents, Injuries)

Allergies to Medicines:

Family History:

What is your Occupation?

Employment status: Full-time | Part-time | Light Duty | Off Duty due to injury | Full-time Parent | Not working | Retired

Physical requirements of your occupation: (prolonged sitting, prolonged standing, phone, computer, lifting, travel, driving, childcare)

Tobacco use: Current | Quit | Never

Number of alcoholic beverages per week?

Number of caffeinated beverages per day?

Review of systems: (Please circle each symptom below if Yes)

What activities do you need help with at home?

• Weight change, night pain, fevers?	Yes	No
• Vision change, double vision?	Yes	No
• Difficulty swallowing, headaches?	Yes	No
• Chest pain, palpitations?	Yes	No
• Shortness of breath, asthma?	Yes	No
• Nausea, vomiting, black stools, stool incontinence?	Yes	No
• Urinary or prostate/gynecologic problems?	Yes	No
• Rashes?	Yes	No
• Dizziness, weakness, numbness, tingling?	Yes	No
• Depression, sleep problems?	Yes	No
• What do you do for exercise?		

Health Care Provider Initials _____