OSPTA
ORTHOPEDIC & SPORTS PHYSICAL THERAPY ASSOCIATES

CERVICAL

Name _____ Preferred name _____

Date of birth ____/____/____ Age ____ Sex: M / F Occupation _____

Referring physician _____ Primary care physician _____

Most recent medical exam ____/____/____ Next exam ____/____/____

For this condition, have you seen any other medical providers? Y / N – please list _____

_____

MEDICAL HISTORY

□Arthritis (□Osteoarthritis □Rheumatoid □Fibromyalgia □Other)
□Osteoporosis / □Osteopenia
□Asthma
□Chronic obstructive pulmonary disease (COPD) □Respiratory distress syndrome (ARDS) □Emphysema □Chronic bronchitis
□Angina or □Irregular heartbeat
□Congestive heart failure or heart disease
□Heart attack (myocardial infarction)
□High blood pressure
□Neurological disease (Such as □multiple sclerosis □Parkinson's)
□Stroke or TIA
□Peripheral Vascular Disease
□Headaches
□Diabetes (□Type I / □Type II)
□Previous accidents (explain/ give dates below)
□Visual impairment (□cataract □glaucoma □macular degeneration)
□Hearing impairment (□hard of hearing □hearing aids)
□Back pain (□neck pain □low back pain □degenerative disc disease □spinal stenosis)
□Kidney, □bladder, □prostate, □urination problems
□Incontinence
□Hypothyroid / □ Hyperthyroid
□Allergies: _____
□Anxiety □panic disorders □depression □other disorders
□Hepatitis / □AIDS
□Prior surgery (list below)
□Prosthesis / Implants
□Sleep dysfunction
□Cancer (Type_____)
□Gastrointestinal disease (□ulcer □hernia □reflux □bowel □liver □gall bladder)
□Gynecologic problems (#children____ #pregnancies ___)

Please clarify any checked items above and provide other medical information _____

_____

_____

List surgeries/dates _____

_____

Family medical problems _____

Last eye exam: _____ What is your hand dominance? □Right □Left

□Smoking - # pack(s)/day_____ □Alcohol - # drink(s)/day_____ □Other substance use _____

Have you recently experienced?

□Unexplained weight loss / gain
□Shortness of breath
□Illness / flu / virus
□Headaches
□Feeling unsteady or fear of falling
□Changes in appetite
□Fever / chills / sweats
□Nausea / vomiting
□Night pain
□Dizziness when getting up from resting flat
□Changes in bowel / □bladder function
□Sexual difficulty
□Dizziness / fainting
□Falls in the past year (number _____)

MEDICATIONS (include over-the-counter) □ I have a list of medications, and have attached it to this form

Drug name	Dosage	How often	Pill/liquid/ Spray/injection	Condition	New (Y/N)

MEDICAL TESTING (List tests related to your current problem – dates: actual or as closely as possible)

	Date performed	Facility where performed	Your understanding of results
□ X –ray	_____	_____	_____
□MRI □CT Scan	_____	_____	_____
□Blood/Urine	_____	_____	_____
□Other	_____	_____	_____

ACTIVITIES: mark those you are currently active with and how many times/week

□Walking □Running □Bicycling □Weights □Swimming □Exercise class_____

□Golf □Tennis □Basketball □Skiing □Soccer □Gardening □Other

_____

How many days/week? _____ Duration each day _____

This is a statement other patients have made. *"I should not do physical activities which (might) make my pain worse."* Please rate your level of agreement with this statement below. (☑Response)

□Completely agree □Somewhat agree □Unsure □Somewhat Disagree □Completely Disagree

CURRENT PROBLEM/REASON YOU ARE HERE:

Describe in your own words _____

ONSET:

□0-7 days □8-14 days □15-21 days □22-90 days □91 days – 6 months □ > 6 months Date: _____

Did it begin □ suddenly or □ gradually what, if known, caused your problem?

_____

Is your problem getting □ better □worse □not changing?

Just before your problem began, were you completely free of discomfort or problems with the area? Y / N

Describe prior episodes including date(s), cause, duration and treatments

_____

PAIN RATING ***right now*** (Circle below)

0 1 2 3 4 5 6 7 8 9 10

No pain worst imaginable pain

0-10 pain over the ***past two weeks*** when at its best/lowest: _____ / 10 worst/highest: ____/10

DESCRIPTION OF DISCOMFORT:

□Ache □Pain □Sharp □Dull □Pins/needles □Tingling □Numbness
□Burning □Throbbing □Cramping □Swelling □Other _____

Is your problem/discomfort □Constant □Intermittent – if so, how often/how long lasting _____

How long can you be symptom free _____ Does coughing or sneezing cause discomfort? Y / N

Does the time of day affect your problem? Y / N When is it better? _____ Worse _____

How does rest affect your problem? □Relieves □Makes worse □No change

What activities/positions aggravate your problem? _____

What activity/positions relieve/decrease your problem? _____

Does discomfort ever awaken you at night? Y / N If yes, # times/night _____ Can you return to sleep? Y / N

Have you had previous physical therapy for this problem? Y / N what was the outcome? _____

Please let us know your goals/expectations: _____

_____

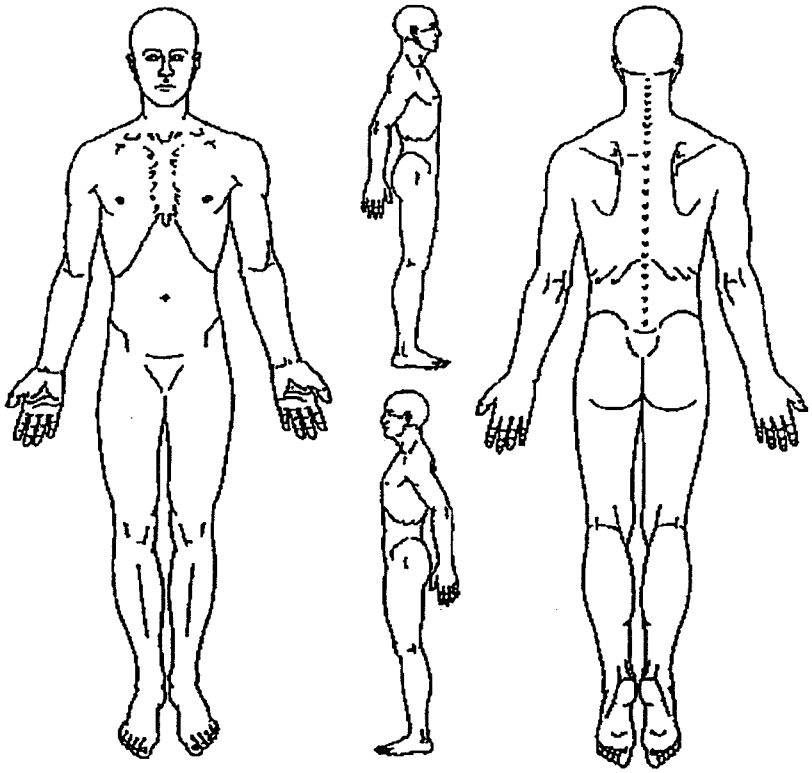
LOCATION OF SYMPTOMS:

When your problem began, was your discomfort in exactly the same location as you have it now? Y / N
If the position of the discomfort has changed, how did it progress from the original location?

_____

Please mark on the body diagram below (with the designated signs) exactly where your current problem is

- ✓ Minimal to moderate pain
- ➡ Radiating pain
- ■ Severe pain
- XX Numbness



Office use only
BP _____ HR _____ Height _____ Weight _____ BMI _____