inspire health
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Name: _____
Date: _____
DOB: _____

Please describe your Primary Complaint(s)

_____

_____

Date of Onset: _____

Did your symptoms come on: (Please check which applies)
❒ Gradual? ❒ Insidious? ❒ Sudden?

Was the onset of your symptoms due to any of the following? (check all that apply)

❒ Injury at home
❒ Chronic symptoms
❒ Insidious Onset
❒ MVA
❒ Work-related
❒ Repetitive Motion
❒ Sports
❒ Recreational Activity
❒ Trauma
❒ Unknown
❒ Other_____

Over the past two weeks are your symptoms:
(Please check which applies)
❒ Improving ❒ Unchanged ❒ Worsening

Have you undergone any of the following diagnostic testing?
❒ X-rays
❒ MRI
❒Bone Scan
❒ Urinalysis
❒Cardiac Stress Test
❒ CT Scan
❒ Blood Test
❒ Doppler Studies
❒ Nerve conduction, EMG
❒ Mammogram
Results from above tests: _____
When is your Next Physician Visit? _____

Do you experience numbness or pins and needles? ❒Yes
❒No If yes, please indicate location _____

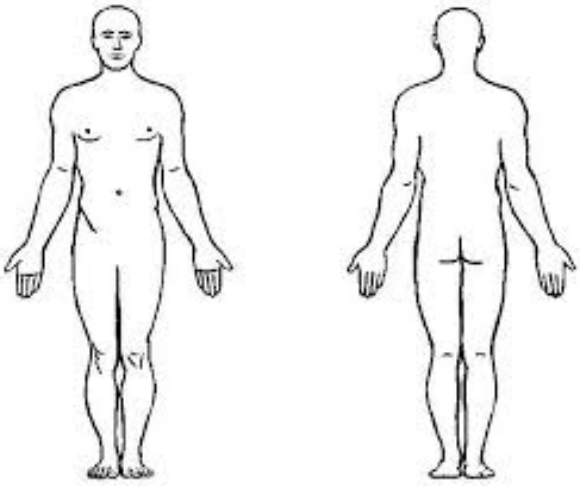
If so, how often?
❒Constant
❒Intermittent/daily
❒Occasional (less than daily)
❒Sporadic (less than weekly)

In the past year have you experienced any of the following? (check all that apply)
❒Nausea
❒Loss of balance
❒Shortness of Breath
❒Night pain
❒ Difficulty walking
❒ Drop Attacks
❒ Coordination Problems
❒ Loss of Appetite
❒ Ringing in the ears
❒ Unexplained weight loss or weight gain
❒Soreness with Exercise
❒ Difficulty Swallowing
❒Unexpected weight loss or gain
❒Dizziness/Vertigo
❒ Loss of Balance
❒ Pain at Night
❒ Hoarseness of Voice
❒ Bowel/Bladder Control Problems
❒Fever (recent) ❒Fatigue

BODY DIAGRAM

Instructions:

On the body diagram below, please indicate where your symptoms are located at the present time. Please do not indicate symptoms that are not related to your present injury or condition.



Pain Scale

0=No pain
1=Mild Pain: you are aware of it but it doesn't bother you
2=Mild Pain: you become more aware of it, but only begins to bother you.
3= Moderate Pain that you can tolerate without medicine
4=More severe pain that requires medication to tolerate
5=Severe Pain: you begin to feel antisocial
6=Severe Pain: you cannot participate in recreational activities
7= Very Severe Pain: you cannot leave the house
8= Intensely Severe Pain: you cannot get out of bed
9=Extremely Severe Pain: you cannot get out of bed
10=Most Severe Pain: It may make you contemplate suicide

Using the scale above what is your pain intensity
At best (0-10)? _____At worst? _____

What is the frequency of your pain? (check all that apply)
❒ Constant
❒ Intermittent/daily
❒ Occasional (less than daily)
❒ Sporadic (less than weekly)

How would you describe the quality of your pain?
❒Dull ❒Steady ❒Sharp
❒ Throbbing ❒Burning

For Women Only:
Have you ever been diagnosed with:
Pelvic Inflammatory Disease? ❒Yes ❒ No
Endometriosis? ❒Yes ❒ No
Trouble with your period? ❒Yes ❒ No
Complicated pregnancies or deliveries? ❒Yes ❒ No
Pregnant or think you might be pregnant? ❒Yes ❒ No
Other gynecological or obstretical difficulties? ❒Yes ❒ No
If yes:_____

Functional Level at Present

(Do any of the following activities provoke your symptoms)

Arm/hand Activities	❒	Lying on Back	❒
Ascending Stairs	❒	Overhead	❒
Bending	❒	Driving	❒
Dressing	❒	Cooking	❒
House Cleaning	❒	Toileting	❒
Computer Use	❒	Work Activities	❒
Twisting	❒	Sitting	❒
Descending Stairs	❒	Reaching	❒
Kneeling	❒	Squatting	❒
Lying on Left Side	❒	Standing	❒
Lying on Right Side	❒	Walking	❒
Lying on Stomach	❒	Walking on Uneven	
Running	❒	Ground	❒

Prior Episodes

Have you had prior episodes of this condition?
❒Yes ❒No **If yes, please answer the following:**

How many prior episodes?
❒ 1 ❒ 2-3 ❒ 3-4 ❒ 4 or more ❒10 or more

When did they occur? _____
How often? ❒ Weekly ❒ Monthly ❒ Yearly ❒ Other
Is the severity ❒ Increasing ❒ Decreasing ❒ Unchanged

Which treatments have you had for THIS condition?
❒ Massage Therapy ❒ Physical Therapy ❒ Time off work
❒ Occupational Therapy ❒ Chiropractic Treatment ❒ Bed Rest
❒ Injection ❒ Acupuncture ❒ Surgery
❒ Medication ❒ None ❒ Other _____

Previous Functional Level

For functional limitations described above, what was your ability prior to your injury/illness?

_____
_____
_____

Medical History

How would you describe your general health?

❒ Excellent ❒ Good ❒ Fair ❒ Poor

List any medications (prescription or over the counter) you are currently on and what they are for:

_____
_____
_____

Please check if you have ever been diagnosed with any of the following:

❒ Anemia	❒ Liver Disease/Problem
❒ Allergies	❒ Loss of Consciousness
❒ Artificial Joints	❒ Metal Implant
❒ Asthma	❒ Osteoarthritis (OA)
❒ Cancer	❒ Osteoporosis
❒ Congenital Heart Defect	❒ Osteopenia
❒ Depression	❒ Pacemaker
❒ Diabetes	❒ Peripheral Vascular Disease
❒ Emphysema	❒ Prostate Problems
❒ Epilepsy/Seizures	❒ Rheumatoid Arthritis (RA)
❒ Sciatica	❒ Scoliosis
❒ Tuberculosis (TB)	❒ Sickle Cell Disease
❒ Glaucoma	❒ Stroke
❒ Gout	❒ Suicidal Thoughts
❒ Heart Disease	❒ Thyroid Problems
❒ Heart Attack	❒ Insomnia
❒ Headaches	❒ Hepatitis
❒ Hemophilia	❒ Lupus
❒ High Blood Pressure	❒ Kidney Infections
❒ HIV/AIDS	❒ Low Blood Pressure
❒ Leukemia	❒ Other_____

Have you ever experienced any other musculoskeletal injuries?
If yes, please describe: _____

Lifestyle

What is your occupation?_____
Are you… ❒ Right hand Dominant ❒Left Hand Dominant

Do you smoke cigarettes? ❒Yes ❒No
If yes, _____ packs per day x _____ years?

Do you drink alcohol? ❒Yes ❒No
How many drinks per week? _____

Do you drink caffeinated beverages? ❒Yes ❒No
How many cups (8 oz.) per day? _____

Are you generally (check box)
❒ Sedentary ❒ Physically Active
What do you enjoy for physical activity
❒ Home ❒ Gym ❒ Free Weights ❒ Machines ❒ Elliptical Trainer ❒ Treadmill ❒ Stationary Bike ❒ Bike ❒ Pool ❒ Exercise Classes ❒ Pilates ❒ Yoga ❒ Other_____