HAMILTON SPINE HEALTH AND SPORT

AMBULATORY CARE SUMMARY

NAME: _____ REFERRING PHYSICIAN: _____
NEXT APPOINTMENT WITH YOUR DOCTOR: _____
PRIMARY PHYSICIAN: _____
DIAGNOSIS/COMPLAINT: _____
OCCUPATION: _____ FULL / LIGHT DUTY (please circle)
WORK OR OTHER RESTRICTIONS PER DOCTOR: _____
WHAT IS YOUR GOAL FOR THERAPY: _____

MEDICAL HISTORY (please circle (Y) for Yes or (No) for NO)

Heart problems/ disease	Y / N	High blood pressure	Y / N
Heart attack	Y / N	Lung disease	Y / N
Pacemaker	Y / N	Asthma	Y / N
History of blood clot	Y / N	Use of blood thinners	Y / N
Bleeding disorder	Y / N	Anemia	Y / N
Diabetes mellitus	Y / N	Headache/migraine	Y / N
Circulation problems	Y / N	Stroke or mini-stoke / TIA	Y / N
Thyroid disease	Y / N	History of cancer (please list)	Y / N
Neuropathy/nerve disease	Y / N	_____	
Seizure disorder	Y / N	History of head injury	Y / N
Osteoporosis	Y / N	History of spine injury	Y / N
History of fracture	Y / N	Rheumatoid arthritis	Y / N
Metal implants (please list) _____	Y / N	Osteoarthritis	Y / N
Behavioral/psychological problems	Y / N	Prednisone use	Y / N
Bowel/bladder problems	Y / N	Skin allergies to one or more of the following:	
Are you or could you be pregnant	Y / N	Latex / beeswax / adhesive	(please circle)

OTHER IMPORTANT MEDICAL INFORMATION: _____

PLEASE LIST YOUR CURRENT MEDICATIONS:

_____

_____

_____

PLEASE LIST ANY ALLERGIES/ALLERGIC REACTIONS:

_____

_____

PLEASE LIST RELEVANT DIAGNOSTIC TESTS AND RESULTS, IF KNOWN (MRI, X-ray, CT Scan, nerve studies, etc)