



Comprehensive History & Physical

Please take a few minutes to complete this worksheet. This information will help us in providing your care.

Name: _____ Date of Birth: _____ Sex: F M

Height: _____ Weight: _____

Is the reason for your visit the result of an accident or injury? Yes No

If yes, Date of injury _____ Work Injury Motor Vehicle Accident

Occupational Disease Other _____

Please describe how the injury occurred:

If No, reason for visit:

Please list:

<u>Current Medications:</u> <input type="checkbox"/> N/A	<u>Previous Surgeries:</u> <input type="checkbox"/> N/A	<u>Drug Allergies:</u> <input type="checkbox"/> N/A
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



Have you ever had or been told you have (Check all that apply): N/A

<input type="checkbox"/> Chest Pain or angina <input type="checkbox"/> Heart Disease <input type="checkbox"/> MI, Heart Attack ,Blocked artery <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Abnormal heart beat <input type="checkbox"/> Pacemaker <input type="checkbox"/> Angioplasty or heart Cath <input type="checkbox"/> Damaged heart valve <input type="checkbox"/> HIV	<input type="checkbox"/> Asthma <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Emphysema <input type="checkbox"/> TB <input type="checkbox"/> Blood Disease <input type="checkbox"/> Glaucoma <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Fainting Spells/Dizziness <input type="checkbox"/> Stroke <input type="checkbox"/> Mediport	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Adrenal Gland Problem <input type="checkbox"/> Steroid Use <input type="checkbox"/> Heat attack/Failure <input type="checkbox"/> Herpes <input type="checkbox"/> Cancer _____ <input type="checkbox"/> Arthritis <input type="checkbox"/> Hepatitis _____	<input type="checkbox"/> Ulcers, heartburn reflux <input type="checkbox"/> Diverticulitis or Colitis <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Anemia <input type="checkbox"/> Dialysis <input type="checkbox"/> Blood thinners <input type="checkbox"/> STD _____ <input type="checkbox"/> Other _____
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Where is your pain/discomfort?

Duration of pain:

Frequency of pain: Constant Rare Seldom

Quality of your pain: Aching Cramping Dull Hot/burning Numbing Pins/needles Pressure

Sharp Shooting Stabbing Throbbing Tingling

Does your pain radiate? Y N If so, where to: _____

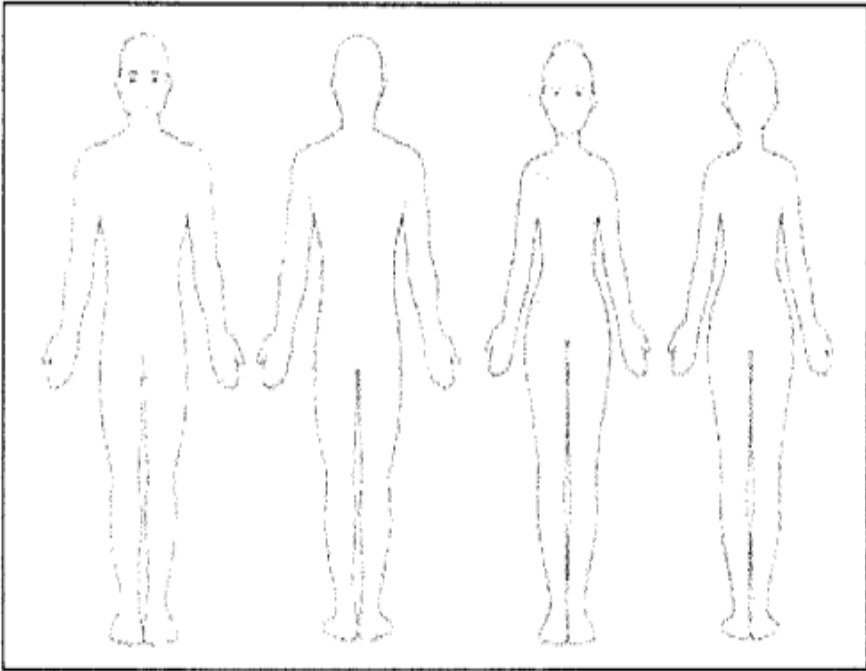
NuThera

Las Vegas: 5765 S. Rainbow Blvd., Suite 111, Las Vegas, NV 89118
 Aliante: 3880 W. Ann Rd., Suite 130, North Las Vegas, NV 89031

(725)-726-7914

admin@nuthera.us

Severity of pain (On a scale of 1-10, 10 being unbearable what number would you rate it):



At its Worst: 1 2 3 4 5 6 7 8 9 10
At its Best: 1 2 3 4 5 6 7 8 9 10
Current: 1 2 3 4 5 6 7 8 9 10

Please Label your symptoms

Stabbing Pain / / / / /
 Burning Pain V V V V V
 Numbness X X X X X
 Aching Pain O O O O O
 Pins and Needles

What makes your pain worse:

- Bending
- Changing Position
- Defecation
- Going up stairs
- Going downstairs
- Heat
- Increased Activity
- Lying Flat

- Lifting
- Movement
- Sitting Long
- Sneezing
- Standing Long
- Standing Straight
- Turning Lett
- Turning Right

What makes your pain better:

- Assistive devices
- Changing Positions
- Cold
- Exercise
- Heat
- Injections
- Lying Flat

- Manipulation
- Medication
- Physical Therapy
- Rest
- Sitting
- Standing
- Walking

History of vertigo/dizziness: N Y
 History of fibromyalgia: N Y

History of falls: N Y

Use any supporting devices: N Y Cane Crutches Walker Wheelchair

Treatment History (As it relates to your visit today)



Previous imaging / area: X-Rays _____ MRI _____

Previous Therapy: How many sessions _____

Previous Injections: When was last injection and where _____

Surgery: Date of procedure _____

Hospitalization: Where _____

Social History

Tobacco Use Yes No

Yes, How many per Day ____ Week ____ Month ____ Rarely / Occasional recreational

Alcohol Use Yes No

Yes, Glasses per Day ____ Week ____ Month ____ Rarely / Occasional recreational



Medical History:

REVIEW OF SYSTEMS: Please check all symptoms you have experienced in the last MONTH.

Constitutional/General

- Fever
- Chills
- Heavy Sweating/Night Sweats
- Loss of Appetite
- Sleep Disturbances
- Unexplained Weight Loss/Gain
- Other: _____

Eyes

- Blurry Vision
- Double Vision
- Wear Glasses
- Other: _____

Ear/Nose/Throat

- Sore Throat
- Mouth Sores
- Nasal Congestion/Sinus Issues
- Hearing Loss
- Other: _____

Respiratory

- Cough
- COPD
- Wheezing
- Recurrent Upper Respiratory Infections
- Shortness of Breath
- Other: _____

Endocrine

- Excessive Thirst or Fluid Intake
- Temperature Intolerance
- Feeling Tired (Fatigue)
- Hot Flashes
- Other: _____

Cardiovascular

- Chest Pain or Discomfort
- Swelling of Feet, Ankles or Legs
- Irregular Heart Beat
- Heart Attack
- Heart Failure
- Palpitations
- Varicose Veins
- Other: _____

Gastrointestinal

- Abdominal Pain
- Nausea/Vomiting
- Indigestion or Heartburn
- Blood in Stools
- Change in Bowel Habits
- Rectal Bleeding
- Diarrhea
- Constipation
- Swallowing Difficulties
- Other: _____

Psychological

- Depression
- Anxiety
- Other: _____

Hematologic/Lymphatic

- Swollen Glands
- Blood Clotting Problem
- Easy Bruising
- Bleeding Tendencies
- Other: _____

Genitourinary

- Painful Urination
- Urinary Frequency
- Loss of Urinary Control
- Enlarged Prostate
- Difficulty Urinating
- Other: _____

Skin

- Skin Rash
- Itching
- Discoloration of the Skin
- Lumps or Masses
- Other: _____

Musculoskeletal

- Joint Pain
- Joint Swelling
- Back Pain
- Limitation of Motion
- Neck Pain
- Pain with Walking
- Other: _____

Neurological

- Tremors
- Dizzy Spells
- Numbness or Tingling
- Headache
- Unsteady Gait
- Feeling Weak
- Convulsions/Seizure
- Other: _____