FUNCTION FIRST
SPINE & SPORT

**LAST NAME:**_____ **FIRST NAME:**_____ **MI:**_____ **DOB:**_____

**Past Medical History:** Please select all conditions that you have had or are currently having:

| Cardiovascular | Yes | No | Year/Explain |
|---|---|---|---|
| Chest Pain | ☐ | ☐ | _____ |
| Pacemaker | ☐ | ☐ | _____ |
| High Blood Pressure | ☐ | ☐ | _____ |
| Heart Attack | ☐ | ☐ | _____ |
| High Cholesterol | ☐ | ☐ | _____ |
| Irregular Heartbeat | ☐ | ☐ | _____ |
| Other:_____ | ☐ | ☐ | _____ |

| Genitourinary | Yes | No | Year/Explain |
|---|---|---|---|
| Kidney Disease | ☐ | ☐ | _____ |
| Kidney Stones | ☐ | ☐ | _____ |
| Burning Urination | ☐ | ☐ | _____ |
| Frequent Urination | ☐ | ☐ | _____ |
| Incontinence | ☐ | ☐ | _____ |
| Other:_____ | ☐ | ☐ | _____ |

| Hematologic/Lymphatic | Yes | No | Year/Explain |
|---|---|---|---|
| Hepatitis | ☐ | ☐ | _____ |
| Blood Clots | ☐ | ☐ | _____ |
| Cancers_____ | ☐ | ☐ | _____ |

| Respiratory | Yes | No | Year/Explain |
|---|---|---|---|
| Asthma | ☐ | ☐ | _____ |
| Emphysema | ☐ | ☐ | _____ |
| Shortness of Breath | ☐ | ☐ | _____ |
| Tuberculosis | ☐ | ☐ | _____ |
| COPD | ☐ | ☐ | _____ |
| Cold/Flu | ☐ | ☐ | _____ |

| Ears/Nose/Throat | Yes | No | Year/Explain |
|---|---|---|---|
| Dizziness | ☐ | ☐ | _____ |
| Hearing Loss | ☐ | ☐ | _____ |
| Sinus Infections | ☐ | ☐ | _____ |
| Difficulty Swallowing | ☐ | ☐ | _____ |
| Jaw Pain | ☐ | ☐ | _____ |

| Eyes | Yes | No | Year/Explain |
|---|---|---|---|
| Glaucoma | ☐ | ☐ | _____ |
| Double Vision | ☐ | ☐ | _____ |
| Blurred Vision | ☐ | ☐ | _____ |

| Gastrointestinal | Yes | No | Year/Explain |
|---|---|---|---|
| Gallbladder Problem | ☐ | ☐ | _____ |
| Constipation | ☐ | ☐ | _____ |
| Diarrhea | ☐ | ☐ | _____ |
| Liver Problems | ☐ | ☐ | _____ |
| Ulcers | ☐ | ☐ | _____ |
| Nausea/Vomiting | ☐ | ☐ | _____ |

| Endocrine | Yes | No | Year/Explain |
|---|---|---|---|
| Thyroid Disease | ☐ | ☐ | _____ |
| Diabetes | ☐ | ☐ | _____ |
| Hair Loss | ☐ | ☐ | _____ |
| Menopausal | ☐ | ☐ | _____ |
| Menstrual Problems | ☐ | ☐ | _____ |

(Women only) Date of Last Menstrual Period _____

Are you pregnant? _____

| Psychiatric | Yes | No | Year/Explain |
|---|---|---|---|
| Depression | ☐ | ☐ | _____ |
| Anxiety | ☐ | ☐ | _____ |
| Unusual Stress | ☐ | ☐ | _____ |
| Loss of Concentration | ☐ | ☐ | _____ |

| Neurological | Yes | No | Year/Explain |
|---|---|---|---|
| Strokes | ☐ | ☐ | _____ |
| Seizures | ☐ | ☐ | _____ |
| Head Injury | ☐ | ☐ | _____ |
| Numbness | ☐ | ☐ | _____ |
| Parkinson's Disease | ☐ | ☐ | _____ |
| Carpal Tunnel | ☐ | ☐ | _____ |
| Spinning Balance | ☐ | ☐ | _____ |
| Chronic Headaches | ☐ | ☐ | _____ |

| Musculoskeletal | Yes | No | Year/Explain |
|---|---|---|---|
| Gout | ☐ | ☐ | _____ |
| Arthritis | ☐ | ☐ | _____ |
| Joint Stiffness | ☐ | ☐ | _____ |
| Muscle Weakness | ☐ | ☐ | _____ |
| Osteoporosis | ☐ | ☐ | _____ |
| Broken Bones | ☐ | ☐ | _____ |
| Joints Replaced | ☐ | ☐ | _____ |

YOUR HISTORY

FUNCTION FIRST
SPINE & SPORT

## Family Medical History: Please select all conditions that run in your family:

| Cardiovascular | Yes | No | Year/Explain |
|---|---|---|---|
| Chest Pain | ☐ | ☐ | _____ |
| Pacemaker | ☐ | ☐ | _____ |
| High Blood Pressure | ☐ | ☐ | _____ |
| Heart Attack | ☐ | ☐ | _____ |
| High Cholesterol | ☐ | ☐ | _____ |
| Irregular Heartbeat | ☐ | ☐ | _____ |
| Other:_____ | ☐ | ☐ | _____ |

| Genitourinary | Yes | No | Year/Explain |
|---|---|---|---|
| Kidney Disease | ☐ | ☐ | _____ |
| Kidney Stones | ☐ | ☐ | _____ |
| Burning Urination | ☐ | ☐ | _____ |
| Frequent Urination | ☐ | ☐ | _____ |
| Incontinence | ☐ | ☐ | _____ |
| Other:_____ | ☐ | ☐ | _____ |

| Hematologic/Lymphatic | Yes | No | Year/Explain |
|---|---|---|---|
| Hepatitis | ☐ | ☐ | _____ |
| Blood Clots | ☐ | ☐ | _____ |
| Cancers_____ | ☐ | ☐ | _____ |

| Respiratory | Yes | No | Year/Explain |
|---|---|---|---|
| Asthma | ☐ | ☐ | _____ |
| Emphysema | ☐ | ☐ | _____ |
| Shortness of Breath | ☐ | ☐ | _____ |
| Tuberculosis | ☐ | ☐ | _____ |
| COPD | ☐ | ☐ | _____ |
| Cold/Flu | ☐ | ☐ | _____ |

| Ears/Nose/Throat | Yes | No | Year/Explain |
|---|---|---|---|
| Dizziness | ☐ | ☐ | _____ |
| Hearing Loss | ☐ | ☐ | _____ |
| Sinus Infections | ☐ | ☐ | _____ |
| Difficulty Swallowing | ☐ | ☐ | _____ |
| Jaw Pain | ☐ | ☐ | _____ |

| Eyes | Yes | No | Year/Explain |
|---|---|---|---|
| Glaucoma | ☐ | ☐ | _____ |
| Double Vision | ☐ | ☐ | _____ |
| Blurred Vision | ☐ | ☐ | _____ |

| Gastrointestinal | Yes | No | Year/Explain |
|---|---|---|---|
| Gallbladder Problem | ☐ | ☐ | _____ |
| Constipation | ☐ | ☐ | _____ |
| Diarrhea | ☐ | ☐ | _____ |
| Liver Problems | ☐ | ☐ | _____ |
| Ulcers | ☐ | ☐ | _____ |
| Nausea/Vomiting | ☐ | ☐ | _____ |

| Endocrine | Yes | No | Year/Explain |
|---|---|---|---|
| Thyroid Disease | ☐ | ☐ | _____ |
| Diabetes | ☐ | ☐ | _____ |
| Hair Loss | ☐ | ☐ | _____ |
| Menopausal | ☐ | ☐ | _____ |
| Menstrual Problems | ☐ | ☐ | _____ |

(Women only) Date of Last Menstrual Period _____

Are you pregnant? _____

| Psychiatric | Yes | No | Year/Explain |
|---|---|---|---|
| Depression | ☐ | ☐ | _____ |
| Anxiety | ☐ | ☐ | _____ |
| Unusual Stress | ☐ | ☐ | _____ |
| Loss of Concentration | ☐ | ☐ | _____ |

| Neurological | Yes | No | Year/Explain |
|---|---|---|---|
| Strokes | ☐ | ☐ | _____ |
| Seizures | ☐ | ☐ | _____ |
| Head Injury | ☐ | ☐ | _____ |
| Numbness | ☐ | ☐ | _____ |
| Parkinson's Disease | ☐ | ☐ | _____ |
| Carpal Tunnel | ☐ | ☐ | _____ |
| Spinning Balance | ☐ | ☐ | _____ |
| Chronic Headaches | ☐ | ☐ | _____ |

| Musculoskeletal | Yes | No | Year/Explain |
|---|---|---|---|
| Gout | ☐ | ☐ | _____ |
| Arthritis | ☐ | ☐ | _____ |
| Joint Stiffness | ☐ | ☐ | _____ |
| Muscle Weakness | ☐ | ☐ | _____ |
| Osteoporosis | ☐ | ☐ | _____ |
| Broken Bones | ☐ | ☐ | _____ |
| Joints Replaced | ☐ | ☐ | _____ |

FAMILY HISTORY

**Surgical History:** Please list any surgeries below:

| | | | |
|---|---|---|---|
| _____ | Year: _____ | _____ | Year: _____ |
| _____ | Year: _____ | _____ | Year: _____ |
| _____ | Year: _____ | _____ | Year: _____ |
| _____ | Year: _____ | _____ | Year: _____ |
| _____ | Year: _____ | _____ | Year: _____ |

**Allergies:** Please select all that you are allergic to:

☐None ☐Other ☐Chemical ☐Environmental ☐Food ☐Medication ☐Seasonal

***If applicable, please list what you are allergic to:_____

_____

**Medications:** Please list any medications you are ***currently taking***:

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Social History:** Please answer the following questions:

Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated ☐Domestic Partnership

Children: ☐Yes, I have ____ child(ren) ☐None

Pregnant? ☐Yes ☐No If yes, what is your due date?_____

Drink Alcohol? ☐Yes ☐No Use Tobacco? ☐Yes ☐No

Uses recreational drugs? ☐Yes ☐No

Smoking Status: ☐Current every day smoker ☐Current some day smoker ☐Never Smoker

☐Former smoker: ☐ Smoker, status unknown☐ Heavy tobacco smoker ☐ Light tobacco smoker

**Circle which one applies to you:** Workout 1-3 times a week 3-5 times a week 5-7 times a week None/ unable

SIGNATURE (or guardian's signature):_____ Date:_____

---

Height:_____ Weight:_____ Blood Pressure:_____ Pulse:_____ Temperature:_____