Confidential Case History for the Dr. John E. Upledger Veterans Therapy Program

November 12th – November 18th 2017

Please complete and return by mail or fax to The Upledger HealthPlex 11211 Prosperity Farms Rd., Suite D-223, Palm Beach Gardens, Florida, 33410 or Fax to 561 627-9231

Today's Date:_____

Name: _____ Date of Birth: ____/____/____ Age: ____ Male/Female

Address:_____City_____State_____Zip_____

E-mail Address:_____ Cell Phone Number: _____

Local Palm Beach Florida Home/Hotel Ph# _____

Emergency Contact Name and Phone# :_____

If Referred, by Whom: _____

Diagnosis/Condition: _____

If you have Medicare, please know that they will not cover this program. SS#_____-_____-_____
Social Security Number

1 Briefly describe your present injury, diagnosis, condition, or symptoms that you are seeking help for.

Primary concern/Major complaint _____

_____

Other concerns/complaints

_____

_____

2. Was the onset - ___ Sudden ___ Gradual ___ Related to accident or trauma

3. When did you first notice major complaints: _____

_____

_____

_____

4. What brought it on : _____

_____

5. Describe your pain _____

6. Has your pain changed in frequency, severity, or character since the onset: _____

7. Has the pain spread to other areas, or is it localized: _____

8. Is it constant or intermittent: _____

9. Are you experiencing - pins and needles/ numbness/ burning (Please circle all that apply)

10. On a pain scale of 0 = none to 10 = unbearable, what is your pain level -

On a Good Day _____ On a Bad Day_____ Today_____

11. Please describe any weakness you are experiencing:

_____

_____

12. Please mark an "**A**" for activities that **A**ggravate or worsen your symptoms, and an "**R**" for those that help to **R**elieve or make them feel better

Standing	_____	Carrying	_____	Sneezing	_____
Sitting	_____	Laying Down	_____	Rising from chair	_____
Walking	_____	Lifting	_____	Rising from bed	_____
Deep Breathing	_____	Turning	_____	Other _____	
Twisting	_____	Coughing	_____	Other _____	

What do you do to provide relief? _____

13. Please describe how this condition is affecting:

Work: _____

Sleep: _____

Functional Mobility *(walking, bed mobility, transfers, driving, etc)*

_____

_____

Activities of Daily Living /Self-Care:_____

_____

Other activities: _____

What was your level of functioning in these areas prior to the onset of your condition?

_____

_____

14. What do you believe is causing, contributing to, or maintaining your condition? _____

_____

15. Please describe any previous treatment you have had for this condition. What do you feel helped/ did not help

_____

_____

_____

16. Has there been a medical diagnosis: Y / N

Diagnosis: _____

By whom: _____Do you agree with this diagnosis? _____

17. How many physicians have treated you for this condition?

_____

18. Have you had recent: X-rays? _____ MRI? _____

Other diagnostic tests? _____

*Please attach copies of **recent reports** only if possible)*

19. Are you taking any of the following? Circle all that apply

Aspirins	Anti-depressants	Diet Supplements	Sleeping Pills	Vitamins
Laxatives	Insulin	Sedatives	Hormones	Herbs

20. Please list any medication you are currently taking:_____

_____

Past Medical History:

21. Have you ever been diagnosed with a heart condition, diabetes or cancer? If so, please describe_____

_____

_____

22. Please describe if you have experienced any of the following in addition to those previously mentioned: *please include approximate dates when they occurred.*

Broken bones _____

Vehicle accidents _____

Other accidents _____

_____

Whiplash _____

Falling on tailbone _____

Major illnesses/ Immune disorders_____

_____

Surgical procedures* _____

** Please include tonsil removal, wisdom tooth removal, plastic surgery, breast augmentation, etc.*

Other Hospitalizations:_____

Dental History

Braces? Y/ N How long?_____ What age?_____

Root canals? Y/ N If so, how many?_____

Mercury Fillings? Y/ N Were they removed? Y/ N

Did you have chelation after they were removed? Y/ N

Do you have: dentures, bridges, any other dental appliances? _____

Social History:

23. Please check your level of daily intake for the following

Item	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Water	_____	_____	_____	_____

24. Please briefly describe your exercise routine _____

_____

25. Do you sleep on your: side _____ stomach _____ back _____

26. How many pillows do you use under your: head/neck _____Elsewhere_____

28. Which is your dominant hand, left or right _____

29. Do you carry a wallet in your back pocket- left or right _____

30. Which shoulder do you carry a purse on, left or right _____

31. Do you live with anyone? _____

32. Do you have anyone dependent on you for care? _____

Are you dependent on anyone for care? In what areas? _____

_____

33. How many stairs in your home _____at entrance of home_____ Railings?_____

34. If applicable, how many pregnancies_____ births_____ were they difficult? If so, please describe

_____

_____

35. Please identify any significant illnesses/ conditions/ circumstances regarding family medical history:

_____

_____

_____

36. What are your hobbies/ What do you enjoy doing recreationally? How is your condition affecting these?_____

_____

Please help us be aware of any of the following precautions:

Are you pregnant? _____

Range of motion restrictions/ Activity limitations: _____

Implantation of medical or dental devices *(cardiovascular, catheters, medicine pumps, IUD, shunts, dentures, other)*: _____

Swallowing/ Food precautions _____

Breathing/ suctioning _____

Positioning Issues _____

Latex Allergies _____

Is there any Concern regarding a change in Intracranial Pressure? Y / N

Other: _____

_____

What are your goals for treatment? _____

_____

_____

_____

What would you like to do that you are currently having difficulty with / unable to do?

_____

_____

_____

If there is anything else you feel we should know to create the most beneficial environment for you, please tell us _____

_____

_____

Is there anyone you request we send a treatment report to? *(ie.yourself, Medical providers, insurance agents) Please provide names, titles, and addresses*: _____

Please circle all symptoms you have difficulty with, and note specific areas as appropriate

Arthritis
Asthma
Anemia
Atrophy
Aneurysm
Bowel/Bladder issues
Blood Pressure- Low / High
Balance problems
Cardiovascular disease
Constipation
Chest pain
Cold hands / feet
Cold sweats
Cognitive changes
Coordination/ Motor planning
Diarrhea
Dizziness
Developmental delays
Depression
Disc Bulge / Herniation
Edema / Swelling
Emotional Status
Face Flushed
Fainting
Fatigue
Grating in Neck
Gallbladder issues
Gas
Hearing
Heart pain or palpitations
Hay Fever
Head feels heavy
Hernia
Intestinal disorders
Immune deficiencies
Inner tension
Irritability
Loss of Smell
Loss of Taste sensations
Low Back or Sacroiliac Pain
Memory changes
Muscle Spasm / Cramping
Mood Swings
Muscle tone
Night sweats
Neuritis/ Neuralgia
Nervousness
Neuromuscular disease
Neurological trauma or disease
Neck Pain
Numbness
Nystagmus
Oral - Motor dysfunction
Painful joints or extremities
Pinched nerves
Paralysis
Perspiration- excessive or diminished
Pins and Needles feeling
Rheumatism
Rib Pain
Sciatica
Sensory Integration Issues
Sensory Changes
Scoliosis
Sinus pain / infections
Speech/ Communication
Swallowing difficulties
Stress
Spondylosis
Spondylolisthesis
Shortness of breath
Strabysmus (lazy eye/ eyes crossing)
T.B.
Twitching
Tone Changes
Tremors
Ulcers
Vertigo
Vestibular dysfunction
Visual deficits / sensitivities

Female Only

Easily fatigued	Vaginal discharge	Melancholia/Depression
Premenstrual mood swings	Painful menstrual cramps	Hysterectomy
Excessive/prolonged	Birth Control Pills	
Menstrual cycle	Scant/missing menstrual	
Painful Breasts	cycle	
Menopausal hot flashes	Breast Implants	

Male Only

Prostate trouble	Burning with urination	Lack of energy
Frequent night urination	Persistent abdominal pain	
Diminished sex drive	Urination difficulty or	
Pain with orgasm	dribbling	
Pain in groin area	Tire easily	

If your current condition is related to a traumatic event or accident please complete the following:

Please describe the significant details regarding how your injury/ accident / trauma occurred:

_____

_____

_____

_____

Was emergency care provided at the scene? YES / NO

If not, when/ where did you seek medical care? _____

Was there a: loss of consciousness at the time?

How long were you unconscious/ comatose? _____

Did you sustain a: Spinal Cord Injury? YES / NO

What level? _____

Is the Classification: complete/ incomplete Anterior Cord Central cord Brown-Sequard

Other: _____

Closed Head Injury? Traumatic Brain Injury?_____

_____

Please list significant details regarding hospital stay:

How long were you in inpatient acute care? _____

Inpatient rehabilitation? _____

Was intubation / ventilator required? _____

Did you have any broken bones? YES / NO

How were they stabilized? _____

Please list surgeries that were performed and when: _____

_____

_____

_____

_____

Were you discharged home with home therapies or outpatient services?_____

_____

Are you currently receiving therapies?

PT: _____ OT: _____

OT: _____

Other: _____