

PATIENT HISTORY

Name _____ Date _____

Current symptoms: _____

When did you first notice your symptoms: _____

Describe how your symptoms began: _____

****Please circle the most appropriate answer in each category****

Description of pain: Sharp Dull Ache Weak Throbbing Numb Shooting Gripping Burning Tingling

Duration of pain: Constant Comes and goes—How often? _____

Does the pain radiate to another area of the body? _____

Frequency of pain: Constant (76-100%) Frequent (51-75%) Occasional (26-50%) Intermittent (0-25%)

Intensity of pain at its lowest and highest level: No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable Pain

Symptoms are: decreasing not changing increasing

Symptoms are worse in the: morning afternoon night increases or decreases during the day same all day

What makes your symptoms *better*? Nothing Lying down Walking Standing Sitting Movement Inactivity

What makes your symptoms *worse*? Nothing Lying down Walking Standing Sitting Movement Inactivity

Have you been treated *for this episode*: Yes No

If yes, by whom? DC MD DO PT OT Self Other Treatment: _____

In the past, have you been treated for the same or similar problem? Yes No

If yes, when and what treatment? _____

How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

Are your complaints affecting your ability to be active?

No effect

Some physical restrictions (able to perform light duty work and household tasks)

Need limited assistance with common everyday tasks

Need assistance often

Have a significant inability to function without assistance

Am totally disabled (impaired) and cannot care for myself

How would you rate your stress level? Little or no stress Minimal Moderate Severe

General physical activity: No exercise Light Moderate Strenuous

Physical activity at work: Mostly sitting Light manual labor Moderate Strenuous Repetitive motion

Occupation: _____ FT PT

Has your work status changed because of this complaint? Y N How? _____

If you have ever had a condition in the past or if you are presently troubled by a particular condition, please circle the condition below. Please write PAST or PRESENT with each chosen condition. The information you provide concerning past and present conditions assists the doctor in more thoroughly understanding your state of health.

Neck pain	Abnormal weight gain or loss	Stroke
Shoulder pain	Excessive thirst	Asthma
Upper arm or elbow pain	Chronic cough	Cancer
Hand pain	Chronic sinusitis	Tumor
Wrist pain	General fatigue	Prostate problems
Upper back pain	Irregular menstrual flow	Blood disorder
Low back pain	Profuse menstrual flow	Emphysema
Upper leg or hip pain	Breast soreness/lumps	Arthritis
Lower leg or knee pain	Endometriosis	Rheumatoid arthritis
Ankle or foot pain	PMS	Diabetes
Jaw pain	Loss of bladder control	Epilepsy
Joint swelling/stiffness	Painful urination	Ulcer
Fainting	Frequent urination	Liver/gall bladder problem
Visual Disturbances	Abdominal pain	Kidney stones
Convulsions	Constipation/Irregular bowels	Hepatitis
Dizziness	Difficulty in swallowing	Bladder infection
Headache	Heartburn/indigestion	Kidney disorders
Muscular incoordination	Dermatitis/eczema/rash	Colitis
Tinnitus (ears ringing)	Depression	Irritable colon
Rapid heart beat	Aortic aneurysm	HIV/AIDS
Chest pain	High blood pressure	Systemic lupus
Loss of appetite	Angina	Other
Anorexia	Heart attack	_____

If a family member has had any of the following, please circle the appropriate condition:

Cancer	Lung problems	Chronic headaches
Rheumatoid arthritis	High blood pressure	Lupus
Diabetes	Epilepsy	Other
Heart problems	Chronic back problems	_____

Do you have a permanent disability rating? Y N

Location: _____ Date rating received: _____ Rating percentage: _____

Please answer any of the following that apply:

Pregnancies: # _____ Complications: Y N
 Birth control pills: Past Present Hormonal/estrogen replacement: Past Present

Medications _____

Hospitalizations/Surgical procedures _____

Tobacco use: Past Present Amount: _____
 Alcohol use: Past Present Amount: _____
 Drug or alcohol dependence: Past Present Amount: _____
 Coffee/tea/soft drinks: Past Present Amount: _____
 Pain relievers: Past Present Amount: _____

Current Height: _____ Current Weight: _____

Activities of Daily Living *How does this condition currently interfere with your life and ability to function?*

	No effect	Mild effect	Moderate effect	Severe effect
Sitting	No	Mild	Moderate	Severe
Rising out of chair	No	Mild	Moderate	Severe
Standing	No	Mild	Moderate	Severe
Walking	No	Mild	Moderate	Severe
Lying down	No	Mild	Moderate	Severe
Bending over	No	Mild	Moderate	Severe
Climbing stairs	No	Mild	Moderate	Severe
Using a computer	No	Mild	Moderate	Severe
Getting in/out of car	No	Mild	Moderate	Severe
Driving a car	No	Mild	Moderate	Severe
Looking over shoulder	No	Mild	Moderate	Severe
Caring for family	No	Mild	Moderate	Severe
Grocery shopping	No	Mild	Moderate	Severe
Household chores	No	Mild	Moderate	Severe
Lifting objects	No	Mild	Moderate	Severe
Reaching overhead	No	Mild	Moderate	Severe
Showering or bathing	No	Mild	Moderate	Severe
Dressing myself	No	Mild	Moderate	Severe
Love life	No	Mild	Moderate	Severe
Getting to sleep	No	Mild	Moderate	Severe
Staying asleep	No	Mild	Moderate	Severe
Concentrating	No	Mild	Moderate	Severe
Exercising	No	Mild	Moderate	Severe
Yard work	No	Mild	Moderate	Severe

What would be the most significant thing that you could do to improve your health? _____

What additional health goals do you have? _____

Additional comments or general health concerns? _____

Signature _____

Date _____