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
Shoulder pain
Upper arm or elbow pain
Hand pain
Wrist pain
Upper back pain
Low back pain
Upper leg or hip pain
Lower leg or knee pain
Ankle or foot pain
Jaw pain
Joint swelling/stiffness
Fainting
Visual Disturbances
Convulsions
Dizziness
Headache
Muscular incoordination
Tinnitus (ears ringing)
Rapid heart beat
Chest pain
Loss of appetite
Anorexia

Abnormal weight gain or loss
Excessive thirst
Chronic cough
Chronic sinusitis
General fatigue
Irregular menstrual flow
Profuse menstrual flow
Breast soreness/lumps
Endometriosis
PMS
Loss of bladder control
Painful urination
Frequent urination
Abdominal pain
Constipation/Irregular bowels
Difficulty in swallowing
Heartburn/indigestion
Dermatitis/eczema/rash
Depression
Aortic aneurysm
High blood pressure
Angina
Heart attack

Stroke
Asthma
Cancer
Tumor
Prostate problems
Blood disorder
Emphysema
Arthritis
Rheumatoid arthritis
Diabetes
Epilepsy
Ulcer
Liver/gall bladder problem
Kidney stones
Hepatitis
Bladder infection
Kidney disorders
Colitis
Irritable colon
HIV/AIDS
Systemic lupus
Other _____

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

Cancer
Rheumatoid arthritis
Diabetes
Heart problems

Lung problems
High blood pressure
Epilepsy
Chronic back problems

Chronic headaches
Lupus
Other _____

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
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?*

Sitting	No effect	Mild effect	Moderate effect	Severe effect
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_____