Name:_____ Date: _____

1. Which of the following best describes how your injury occurred? (if your injury is post-surgical, please indicate original injury.)

- ❑ Lifting
- ❑ A fall
- ❑ An accident
- ❑ Overuse (cumulative trauma)
- ❑ During recreation/Sport
- ❑ Car Accident (State Occurde)_____
- ❑ Dental Appointment
- ❑ Degenerative Process
- ❑ Unknown
- ❑ Other:_____

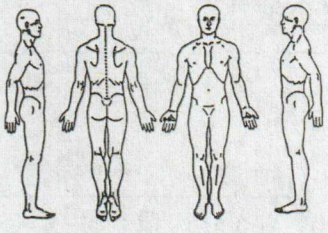
* Please indicate the date your symptoms began: (specific if possible) _____/_____/_____

Date of Surgery:_____/_____/_____

2. Nature of primary complaint:__Pain __Numbness/Tingling

__Sharp	__Burning
__Dull	__Intermittent
__Throbbing	__Constant
__Aching	__Weakness

Other:_____



Please circle the areas where pain is occuring

Place an "X" on the line below indicating your pain at its lowest and highest levels.

0 |__|__|__|__|__|__|__|__|__|__|__| 10

4. Since onset, are your symptoms getting:

❑ Better ❑ Worse ❑ No Change

5. What relieves (R) / aggravates (A) your symptoms?

__ Sitting	__ Rest	__ Massage
__ Heat	__ Standing	__ Medication
__ Cold	__ Lying Down	__ Walking
__ Stretching	__ Exercise	__ Nothing
__ Wearing a splint	__ Coughing/sneezing	

__ Other:_____

6. As the day progresses do your symptoms:

❒ Increase ❒ Decrease ❒Stays the same

7. Does pain wake you at night? __ Yes __ No

If yes, is it present:

❒ Lying still ❒ Changing positions ❒ Both

8. What position do you sleep?

❒ Right side	❒ Left side	❒ Back
❒ Stomach	❒ Chair/recliner	❒ Back, side

❒ Other:_____

9. Do you have any pain/stiffness getting out of bed?

___ Yes ___ No

10. Since your symptoms began you had:

- ❒ None ❒ Weakness ❒ Headache
- ❑ Fever / chills / nausea / vomiting
- ❒ Any numbness in genital / anal area
- ❒ Unexplained weight changes
- ❒ Dizziness / fainting
- ❒ Nights sweats / pain
- ❒ Problems with vision / hearing / speech
- ❒ Any difficulty with bladder / bowel function
- ❒ Other:_____

11. Current Limitation: (check all that apply)

❒ None	❒ Standing	❒ Looking overhead
❒ Walking	❒ Squatting	❒ Up/down stairs
❒ Reaching	❒ Bending	❒ Taking a deep breath
❒ Sitting	❒ Swallowing	❒ Going from sit to stand
❒ Lying Down	❒ Taking a deep breath	
❒ Talking/chewing/yawning		❒ Self care/hygiene
❒ Sports/ Recreation		❒ Home activities

12. Treatments previously received for this condition:

❒ None	❒ Medication	❒ Biofeedback/TENS
❒ Chiropractic	❒ Injection/acupuncture	
❒ Physical Therapy	❒ Massage	❒ Hospitalization
❒ Bracing/taping	❒Other:_____	

13. What is your primary goal?

- ❒ Return to work ❒ Return to daily activities
- ❒ Return to sport ❒ Prevent procedure
- ❒ Other: _____

continue →

14. Please check/list any other health care providers you are currently seeing for this condition:
❒ None ❒ Physical Therapist ❒ Podiatrist
❒ MD ❒ Dentist ❒Chiropractor ❒ VA
❒ Other: _____

15. Please check if you have any of the following:
❒ None ❒ EMG
❒ CT Scan/MRI ❒ X-rays
❒ Other:_____

General Health

Age:_____ Height:_____ Weight:_____
Dominant Hand:_____ Right _____Left

How do you rate your overall health?
❒ Excellent ❒ Average ❒ Poor ❒ Good ❒ Fair

Are you pregnant: _____ Yes ___No Due Date:___/___/_____

Apart from your daily activities, do you exercise?
❒ 5+ days/week ❒ 3-4 days/week ❒ 1-2 days/week
❒ Occasionally ❒ None

Do you Smoke: ___ No __Yes Packs per day:_____

What is your stress level:
Low I__I__I__I__I__I__I__I__I__I__I High

Medication

Please list any prescription and/or over the counter medications you are currently taking (pain pills, injections, skin patches, aspirin, multi vitamins, ect.)
❒ see attached list

_____ _____
_____ _____

Past & Current Medical History

Have you ever had/been diagnosed with any of the following conditions? (check all that apply)
❒ Cancer ❒ Chemical Dependency ❒Thyroid
❒ Depression ❒ High Blood Pressure ❒ Diabetes
❒ Stroke ❒ Heart Problems ❒ Kidney Problems
❒Allergies ❒ Stomach Problems ❒HIV
❒Arthritis- OA/RA ❒ Blood disorder/Anemia
❒ Fractures ❒ Head Injuries ❒Infectious Disease
❒ Parkinson's ❒ Circular/Vascular Problems
❒ Lung problems/Asthma ❒ Epilepsy/Seizures/Dizziness
❒ Incontinence ❒ Spine Problems
❒ Other:_____

Family History

Has anyone in your family ever been diagnosed with any of the following?
❒ Diabetes ❒ Heart Disease ❒ Cancer ❒ Stroke
❒ High Blood Pressure ❒Arthritis/OA/RA
❒ Psychological Condition ❒Other: _____

Living Situation

❒ Live alone ❒ live with family/ others/ caregiver
❒ Home/Apartment/retirement complex
❒ Independent/assisted ❒ Driving ❒ Other:_____

Environment

❒ Stairs (railing) ❒ Stairs (no railing) ❒Elevator
❒ No Stairs ❒Other:_____

Previous Functional Level

❒ **Independant in all activities**

Self Care
❒ Independant (bathing, toileting, dressing, ect.)
❒ Difficulty performing self-care activities
❒ Need assistance with self-care activities
❒ Difficulty performing household chores

Social/Recreational/Leisure
❒ Limited in _____

Work History

Occupation:_____
❒ Full-time ❒ Part-time ❒ Student ❒ Self
❒ Unemployed ❒ Retired ❒Other: _____

Physical activities at work
❒ Sitting ❒ Phone usage ❒ Standing ❒ Driving
❒ Repetitive lifting ❒ Computer use
❒ Heavy Lifting ❒ Heavy Equipment Operation

Current working Status
❒ Full duty ❒ Restricted duty ❒ Missed days

If not performing your normal activities at work do you plan to return to your previous activity level?
___Yes ___No
Is this a Work Comp claim? __Yes __No
Are you seeking disability or using an attorney for this condition? ___Yes ___No