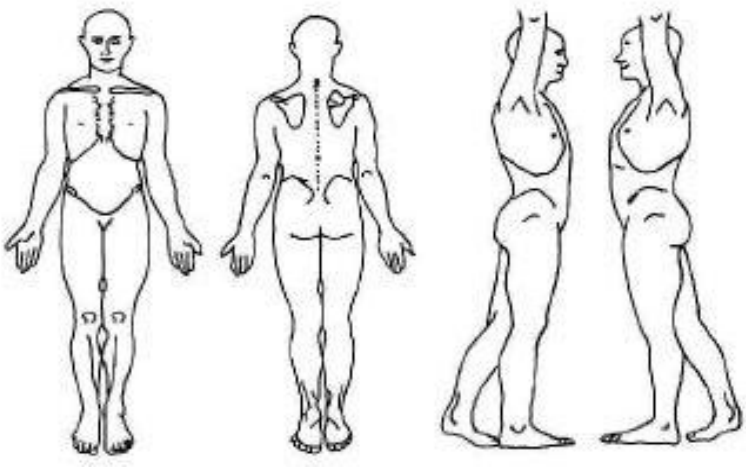
MEDICAL HISTORY

NAME _____

1. How and when (date) did the present injury occur? _____
_____
_____

2. What are your functional problems with this condition? _____
_____
_____

3. Indicate on body diagram where your pain is located.



4. On a scale of 0-10(10 being excruciating) how painful was it when it started? (circle number)
1 2 3 4 5 6 7 8 9 10

5. What is it at its best and worst? (circle numbers)
1 2 3 4 5 6 7 8 9 10

6. How is it today? (circle number)
1 2 3 4 5 6 7 8 9 10

7. Describe the pain (i.e. sharp, dull, ache, numb, etc)
_____

8. What activities make your pain worse?
_____
_____

9. What if anything eases your pain? _____

10. Do you have any problems with your bowels or bladder? _____

11. Have you had anything similar before? _____

12. What started this problem? _____

13. Have you had diagnostic medical tests for this, if so where can they be located? _____
_____

14. Please list all medications, dosage and purpose.
_____
_____
_____

(OVER)

15. Do you smoke tobacco? _____

16. Please list all surgeries and approximate dates.
_____
_____
_____

17. Have you seen anyone else for this problem? If so, please list.
_____
_____
_____

18. Do you exercise regularly? _____

Past or current medical history; check all that apply:

_High blood pressure	_Heart disease	_Chest pain	_Respiratory problems
_Lung disease	_Heartburn	_Upset stomach	_Thyroid condition
_Diabetes	_Low blood sugar	_Cancer	_Osteoporosis
_Headaches	_Joint disease	_Swelling	_Fractures
_Vision problems	_Hearing problems	_Arthritis	_Hepatitis
_Psoriasis	_Stroke	_Tuberculosis	_Dizziness/Fainting
_Metal or other implants	_Tumor/cyst	_Epilepsy/seizures	_Pacemaker
_Other			

19. What are your goals with therapy? _____
_____
_____

To the best of my knowledge, the information I have provided is accurate and complete.

_____ _____
Patient's Signature Date