

Patient History

Name: _____ Email: _____

Age: _____ Occupation: _____ Presently working? Y N

Activities/Exercise Routine _____

Current Condition:

1. What major complaint, symptom or problem brings you here?

2. What activities aggravate your condition?

3. What relieves your symptoms?

4. Progression of current condition (circle one): better worse same

5. Please rate your pain on a scale of 0-10: (circle one)

0 1 2 3 4 5 6 7 8 9 10

Mild

Moderate

Severe

6. What tests/and or treatment have you had performed for this

problem? _____

7. What medications are you taking for this problem? _____

Other Medications? _____

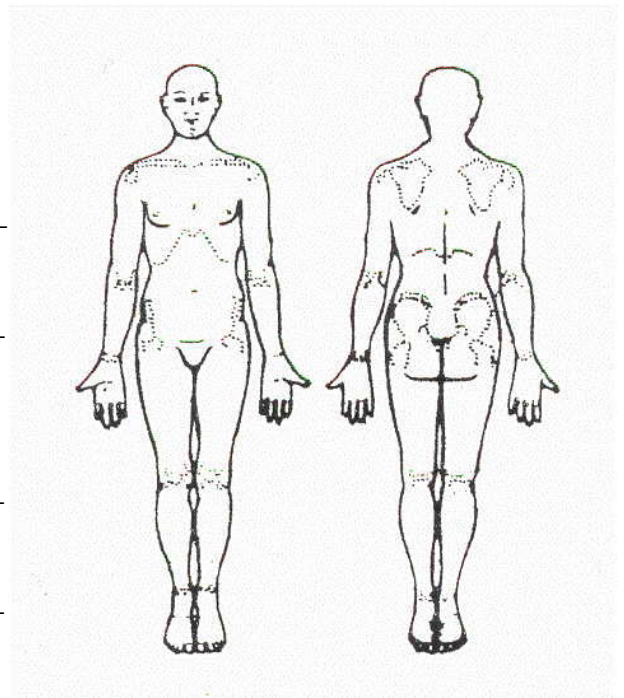
8. Past Medical History: Have you been diagnosed with or experienced any of the following?:

- | | |
|------------------------|-------------------------|
| Allergy | Numbness |
| Balance | Neurologic condition |
| Bowel/Bladder Problems | Osteoarthritis |
| Cancer Type _____ | Osteoporosis |
| Cardiac condition | Psychological condition |
| Chemical dependency | Respiratory |
| Diabetes | Rheumatoid Arthritis |
| Dizziness | Seizures |
| Gastrointestinal | Thyroid |
| Headaches/Migraines | Weakness |
| Hypertension | Other _____ |

9. To what extent are your daily activities limited?

(circle one) Mild Moderate Severe

10. What are your goals for coming to therapy?



Please shade areas of pain in above picture.
 Circle all that apply:

Aching

Sharp

Dull

Only with movement

Numbness

Tingling

Shooting

Therapist's Notes: