



PATIENT MEDICAL HISTORY

Please check all that apply to you:

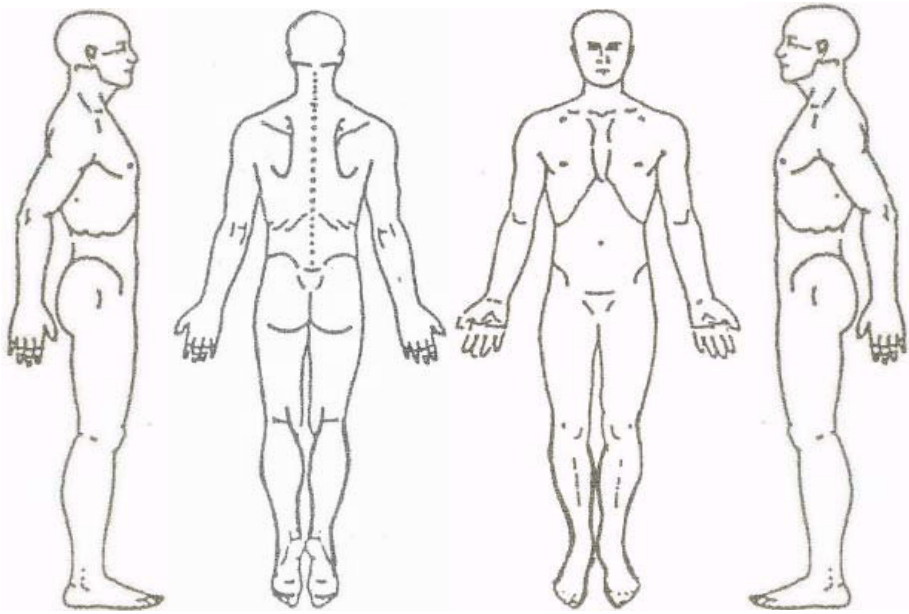
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Where?		
Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Where?		
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint / Muscle Pain		
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shoulder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Elbow	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma / Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Wrist / Hand	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Upper Back	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Irregular Heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mid Back	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Back	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	SI Joint	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hip	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest pain at rest?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Knee	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- with exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ankle / Foot	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:		
Where?			Surgeries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
When?			List:		
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Speech,	<input type="checkbox"/> Yes	<input type="checkbox"/> No
List:			swallowing, or		
			thinking problems		

If checked, please explain: _____

If there is a condition not indicated above, please include in the "Other" section and explain:

Prior physical therapy (if yes, please explain): _____

Medication(s): _____



Please mark the diagram with the following symbols to describe where your pain is.

↑ or ↓	KEY
XXX	Radiating Pain
ZZZ	Spasm
/////	Tenderness
0000	Numbness/Tingling
	Ache/Pain

Please rate (circle) your pain on a 0-10 scale (0 = no pain; 10 = excruciating pain)

At this time: 0 1 2 3 4 5 6 7 8 9 10 Worst pain: 0 1 2 3 4 5 6 7 8 9 10

Least amount of pain: 0 1 2 3 4 5 6 7 8 9 10

How would you describe your pain:

- Shooting Prick Throb Ache Pull Dull Burn Sharp
- Other _____

As it relates to your current problem, are you unable to or have difficulty with performing any of the following activities due to pain and / or weakness? Check all that apply:

- Getting in/out of a car Getting in/out of bed Shaving Writing Sleeping
- Getting in/out of a chair Brushing teeth Cooking Dressing Eating
- Personal hygiene activities Work Activities Shopping Sitting Driving
- Walking up/down stairs Bathing/Shower Standing Laundry Vacuuming
- Getting in/out of shower Walking Lifting Cleaning

Other: _____

What relieves pain? (Please check all that apply)

- Medication _____
- Massage Relaxation techniques Rest Heat Cold Sleep Repositioning
- Exercise _____ Other _____

What causes pain to increase? _____

Patient Name (Printed): _____

Date: _____

Patient Signature: _____