***Patient History Form*** **Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you on light or restricted duty due to your injury? Yes / No

**Do you currently smoke tobacco?** Yes / No ***If Yes, how much?*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you exercise regularly?** Yes / No ***If Yes,*** *\_\_\_\_\_\_* ***days/week and type of activity:*** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Medical History:*** (please check if you have ever had or been diagnosed with)

|  |  |  |
| --- | --- | --- |
| * Osteoarthritis
* Rheumatoid Arthritis
* Parkinson’s Disease
* Fibromyalgia
* Broken bone/fractures
* Lupus
* Osteoporosis/Osteopenia
* Kidney Problems
* Ulcers/Stomach Problems
* Skin Diseases
* Stroke/TIA
 | * Low blood sugar/Hypoglycemia
* Heart Condition (Pacemaker: Yes/No)
* Circulation/Vascular Problems
* High Blood Pressure
* Cancer

*Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Last episode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Allergies

*Please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | * Latex Sensitivity
* Lung Problems/Asthma
* Depression/Anxiety
* Mental Illness
* Thyroid Problems
* Diabetes/High blood sugar
* Lyme’s Disease
* Head Injury/Concussion
* Multiple Sclerosis
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Have you ever had Orthopedic surgery?** If so please list what type and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any other type of surgery?**  If so please list what type and when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had diagnostic testing?**  Please circle all that apply: X-ray MRI NCV/EMG CAT scan DEXA Bone Scan

On what body part? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Where did you have the testing done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Medications:*** *If you have a current list of meds, we can make a photocopy, otherwise please list below*

**Prescription Medications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Over the Counter Medications:** Please circle all that apply: Advil Motrin Aleve Tylenol

**Vitamins/Herbals/Supplements/Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please complete the following section regarding your pain and symptoms:***

**When did your pain/discomfort/current condition start or change that made you seek medical treatment?**

*(list month/day/year, please estimate if exact date is unknown)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Please mark the area(s) you feel pain/discomfort:** | **Is your pain constant or intermittent?** *(please circle answer)***Please rate your pain on a scale of 0 to 10:****(0 is no pain, 10 is emergency room pain)**Pain at best: \_\_\_\_\_/10Pain currently: \_\_\_\_\_/10Pain at worst: \_\_\_\_\_/10**How would you describe your pain?** *(please circle all that apply)* Burning/throbbing/dull/achy/sharp/shooting/numbness/tinglingother: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**What makes your pain worse?** *(please circle)*sitting/standing/walking/bending/lifting/squatting/reaching/stress

**What makes your pain better?** *(please circle)* rest/sitting/standing/walking/lying down/heat/ice/medication

**If you are not experiencing pain, what symptoms are you seeking treatment for?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What types of activities are you limited performing due to your current condition?** *Please circle all that apply.*

* **Self-care:** dressing/bathing/toileting/household chores/caregiving
* **Body Position/Transfers:** sitting/standing/squatting/getting in or out of bed/chair/car
* **Mobility:** walking/running/going up and down stairs/reaching/pushing/pulling/hand use
* **Occupational:** *(please list)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* **Recreation/Sports:** *(please list)* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please turn over and complete functional questionnaire... Thank You!***