

Name: _____

Physician: _____



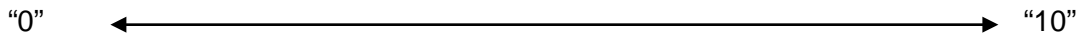
Dear Patient: Please provide us with this important health history information. If you don't understand a question, your therapist will assist you. Thank you.

- 1. For what condition are you seeking treatment here? _____
- 2. Date of onset of condition. _____
- 3. Cause of condition? _____
- 4. Have you been treated for this or a similar condition before? No Yes (Continue with the following)
 - No Treatment Medical Doctor Chiropractor Exercise Medication
 - Physical Therapy Heat / Ice Other: _____

- 5. What are your symptoms? Pain Numbness Weakness Tingling
- Loss of Motion Nausea Dizziness Other: _____

*If you have pain, please complete this section, if not please skip to question 7.

- 6. A. Rate the average amount of pain you have using a "0" to "10" scale where "0" equals no pain and "10" equals the worst pain imaginable. Mark the line at the point that represents your pain.

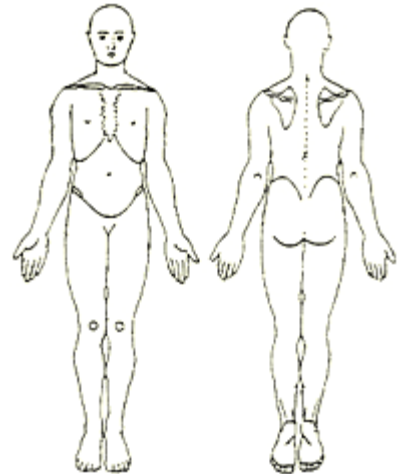


- B. Please mark areas of pain on the diagram to the right...

- C. Is your pain getting: Better Worse Same
- Pain is: Constant Off On Various

- D. Time of day pain is worse: Upon Wakening
- A.M. Midday P.M. Late Night
- Sleep is disturbed Varies Same

- E. What makes the pain worse: Lie Sit Sit-Stand
- Stand Walk Bend Lift Stairs
- Reach Deep Breath Cough/Sneeze
- Rotate Trunk Left Rotate Trunk Right
- Turn Head Left Turn Head Right Other: _____



- F. Pain is better with: Medication Heat Ice Rest Position/Posture
- No Relief Other: _____

- 7. Diagnosis tests done? None X-ray MRI CT Scan Arthrogram Other: _____
- 8. On the job injury? No Yes - Light Duty?: No Yes - Restrictions: _____
- 9. Occupation _____ Physical Demand of Job: Lifting Sitting Phone
- Computer Overhead Driving Extended Standing
- 10. A. Exercise/Activity level prior to onset of condition: Walk Run Bike Swim
- Weight Train Aerobics Class Sport: _____ How many times per week? _____
- B. Exercise level now: None Reduced Same

