PATIENT HISTORY FORM

Please assist us by answering the following questions as completely and accurately as possible. Your answers will assist us by outlining your present symptoms and important medical/injury history, as well as provide us with information that will aid us in the preparation of medical reports requested in the future. Comprehensive history and assessment of your problem is the beginning to successful rehabilitation process. Thank you for your cooperation.

- **Please print clearly and legibly**.
- If you have questions, regarding an item, mark it with a * and your therapist will clarify it. If you need to write more please write on the back of the sheets.

NAME: ______________________ **TODAY'S DATE:** ____________________

SEX: **M F** **DATE OF INJURY:** __________________

DATE OF BIRTH: ____________ **AGE:** ______________________________

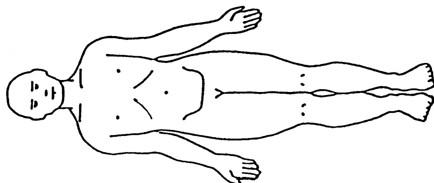
LIST YOUR PROBLEM AREAS (i.e. neck, lower back, shoulder, etc.)

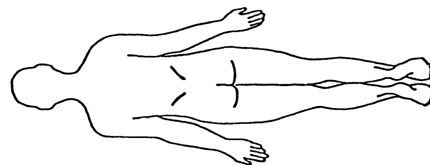
1. Problem #1 ____
2. Problem #2 ____
3. Problem #3 ____
4. Problem #4 ____

WHERE ARE YOUR SYMPTOMS?

Following are body drawings. Please **SHADE** in the appropriate areas of PAIN, and XXX the areas of NUMBNESS, (pins & needles, tingling), if these words describe your current symptoms. If you do not get these symptoms, please leave the drawings blank.

PROBLEM AREAS:





PROBLEM #1 ________________________

Did the problem begin *suddenly* or *gradually* (over what period of time)?______________
How long have you had this problem? ____
Was there an incident that brought on the problem? (Please describe i.e. how did it start) _

____

If the problem is **PAIN** what is its intensity over **the last 24 hours** on a pain scale below:

0 (no pain) ____________________________ 10 (the worst pain imaginable)

1 2 3 4 5 6 7 8 9

CIRCLE the **WORDS** that best describe your pain:

- Superficial or deep
- Constant or intermittent
- Increasing, decreasing, or staying the same
- Worse in the morning or evening
- Dull ache, sharp, shooting, throbbing

Has the pain stayed where it started or has it spread? (Please describe.) _______________

____

What makes your pain **WORSE**? i.e. sitting, driving, standing, any sports, job duties, etc.

____

____

Does coughing or sneezing make your pain worse? YES NO

Does the pain disturb your sleep? YES NO

If YES, does it prevent you from *getting to sleep* or does it *wake you from sleep*? (Circle)

What makes your pain **BETTER**? i.e. rest, certain postures or exercises, medications, etc.

____

____

In what position do you sleep? ____

What type of bed do you sleep on? ____

What type of pillows do you use, and how many? _________________________________

PROBLEM #2 ________________________

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Did the problem begin *suddenly* or *gradually* (over what period of time)?______________
How long have you had this problem? ____
Was there an incident that brought on the problem? (Please describe i.e. how did it start) _

____

If the problem is **PAIN** what is its intensity over **the last 24 hours** on a pain scale below:

0 (no pain) ____________________________ 10 (the worst pain imaginable)

1 2 3 4 5 6 7 8 9

CIRCLE the **WORDS** that best describe your pain:

- Superficial or deep
- Constant or intermittent
- Increasing, decreasing, or staying the same
- Worse in the morning or evening
- Dull ache, sharp, shooting, throbbing

Has the pain stayed where it started or has it spread? (Please describe.) ________________

____

What makes your pain **WORSE**? i.e. sitting, driving, standing, any sports, job duties, etc.

____

____

Does coughing or sneezing make your pain worse? YES NO

Does the pain disturb your sleep? YES NO

If YES, does it prevent you from *getting to sleep* or does it *wake you from sleep*? (Circle)

What makes your pain **BETTER**? i.e. rest, certain postures or exercises, medications, etc.

____

____

In what position do you sleep? ____

What type of bed do you sleep on? ____

What type of pillows do you use, and how many? __________________________________

If you have more than 2 problems please ask for more paper and address the above questions again.

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HAVE YOU EXPERIENCED?: (*please tick and comment on it if appropriate*)

CONDITIONS/SYMPTOMS	YES	NO	PAST	COMMENTS
Dizziness (are you or the room spinning)				
Nausea/Vomiting				
Balance problems				
Change in vision				
Change in hearing				
Change in bowel or bladder function				
Change in sexual function				
Altered sensation in the groin/crotch region				
Numbness in the face				
Ringing or Fullness in your ears				
Sudden loss of balance, possibly associated with turning your head ('drop attack')				

HEADACHES: If you get headaches please fill in the following.

- When did your headaches start? ____
- How often do you get headaches? ________ How long do they last? __________
- What is the location of the headache? _____ Does the location change? ________
- Where does it start? _____________ Where does it spread to? _______________
- Possible cause of headaches – known or unknown? ________________________
- Does medication relieve your headache? ________________________________
- Do you have a history of headaches? YES NO (Circle)
- If YES, are these headaches the SAME or DIFFERENT?

In general, is your health:

Poor ______________ Good _____________ Excellent ________________

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Incontinence:

Have you ever lost control of your bladder or bowels (leaking urine and/or feces) when:

- Coughing YES NO ______________________
- Sneezing YES NO ______________________
- Laughing YES NO ______________________
- Exercising YES NO ______________________
- Other times? ______________________

Do you ever feel the urge to urinate and then are not able to? YES NO

Do you need to wear pads in your undergarments to absorb leakage? YES NO

If YES, how many pads per day? __________

Do you get pain with bladder/bowel movements or with sexual intercourse? YES NO

Is your pain worse during menstruation? YES NO

WOMEN: Describe any pregnancies and deliveries including year, problems in pregnancy, the delivery itself, problems after the pregnancy, incontinence, etc.

____

____

Do you:

- Smoke cigarettes? Cigars? YES NO If YES: # per day:
- Smoke a pipe? YES NO If YES: # per day:
- Take street drugs? YES NO
- Drink alcohol? YES NO If YES: # per day:
- Take steroids now/in the past? YES NO
- Take vitamins/other supplements? YES NO

OCCUPATION

Please describe your job in relation to the time spent doing what type of activities per day, i.e. 15 minutes per hour of standing, the other 45 minutes sitting. Also, note if you think anything in your work environment influences your injury/pain, i.e. physical setup, task restraints, job demands, stress levels.

____

____

____

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MEDICATIONS: Currently taking.

Medications	Reason for Medication	How long have you been taking them?

MEDICAL HISTORY Have you ever been diagnosed with any of the following? (√)

Conditions	YES	NO	Past	Comments
Cancer				
Diabetes				
Heart conditions				
High blood pressure				
Thyroid disorders				
Lung conditions				
Rheumatoid arthritis				
Ankylosing spondylitis				
Other arthritis				
Epilepsy				
Fibromyalgia				
HIV				
Asthma				
Anemia				
Osteoporosis				
Are you pregnant?				
Are you amenorrheic?				

Have you had any other injuries or trauma? ____

- Car Accidents? YES NO (If YES, please answer the questions on page #8).
- Sports Injuries? (please describe) ____
- Broken Bones? (please describe) ____

Have you had any recent surgery? (Please describe) ________________________________

____

Have you had major surgery in the past? (please describe) ___________________________

____

Do you have: Allergies _________________ Metal Implants __________________

Pacemaker ________________ IUD ___________________________

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SPECIAL TESTS: Have you had any of these investigative tests done?

TEST	Area Examined	WHEN? Month/year	DOCTOR To contact for results	RESULTS (in brief) if known
X-RAY				
CT SCAN				
MRI				
OTHER; Please specify				

PREVIOUS TREATMENT:

Have you had treatment for previous or for your present injuries?

- Physical Therapy:

When?	Where? (optional to answer)	Results of Treatment	Comments
		Better Worse Same	
		Better Worse Same	

- Chiropractic:

When?	Where? (optional to answer)	Results of Treatment	Comments
		Better Worse Same	
		Better Worse Same	

- Massage:

When?	Where? (optional to answer)	Results of Treatment	Comments
		Better Worse Same	
		Better Worse Same	

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FAMILY/SOCIAL SITUATION

Are you married, single, divorced, common-law, other (*please circle*) ________________

Do you have anyone who is dependent on you such as (*briefly describe situation*):

- Kids: (*ages and number of kids*): ____
- Elderly Parents that you care for: ____

RECREATION

Do you have any hobbies/activities/volunteer work? (*Please describe in brief*) _________

____

____

Do you exercise regularly? (*Please describe in brief*) ______________________________

____

MOTOR VEHICLE ACCIDENT INFORMATION (MVA)

Please complete only if relevant. Please list DATES of all MVA or accidents that you have been in, (most recent first, then so on).

1. ____
2. ____
3. ____

Briefly describe the most recent MVA, i.e. direction of travel, your position in the vehicle, location of impact, airbag deployment, seat belt use, etc.

____

____

____

What direction was your head turned? ____

Were you wearing your seat belt? ____

Did your head hit anything? ____

When did your symptoms begin? ____

How did you leave the accident? ____

Did you seek medical attention (when, who, where)? ______________________________

Are there legalities pending? ____

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