

## Brief Medical History

Patient Name: \_\_\_\_\_

1. **What** is your primary complaint? \_\_\_\_\_

2. **When** did your symptoms start? \_\_\_\_\_

Mark the location(s) of your pain

3. **How** did your symptoms start? \_\_\_\_\_

4. What is your **average** pain intensity?

0 1 2 3 4 5 6 7 8 9 10

5. What is your pain intensity at its **worst**?

0 1 2 3 4 5 6 7 8 9 10

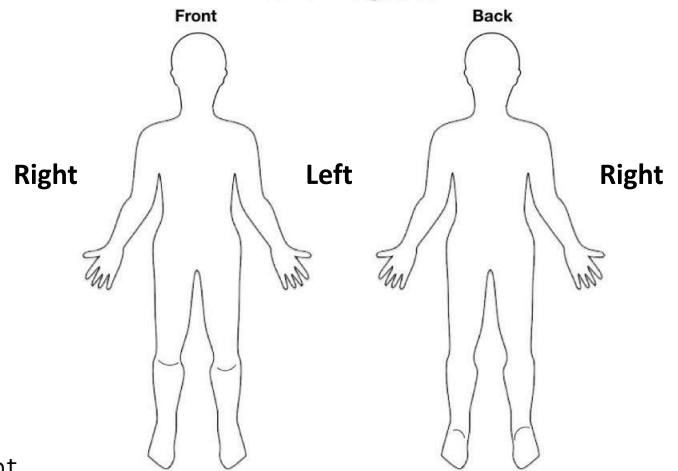
6. What limitations do you have as a result of this complaint  
i.e. with which activities or postures do you notice this complaint?

7. What makes your symptoms **better**? \_\_\_\_\_

8. What makes your symptoms **worse**? \_\_\_\_\_

9. List any previous orthopedic surgeries and approximate dates: \_\_\_\_\_

10. Have you had any previous therapy for this complaint? \_\_\_\_\_



### Please indicate if you have a history of any of the following conditions:

- |  |   |                                |
|--|---|--------------------------------|
| <input type="checkbox"/> Alzheimer's           | <input type="checkbox"/> Cardiovascular Disease         | <input type="checkbox"/> Other |
| <input type="checkbox"/> Cauda Equina Syndrome | <input type="checkbox"/> Cerebral Vascular Accident     | _____                          |
| <input type="checkbox"/> Diabetes Type 1       | <input type="checkbox"/> Diabetes Type 2                | _____                          |
| <input type="checkbox"/> Fibromyalgia          | <input type="checkbox"/> Fracture or Suspected Fracture | _____                          |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> History of Cancer              | _____                          |
| <input type="checkbox"/> Huntington's          | <input type="checkbox"/> Immunosuppression              |                                |
| <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Muscular Dystrophy             |                                |
| <input type="checkbox"/> Osteoarthritis        | <input type="checkbox"/> Parkinson's                    |                                |
| <input type="checkbox"/> Rheumatoid Arthritis  | <input type="checkbox"/> Traumatic Brain Injury         |                                |

Patient Signature \_\_\_\_\_ Today's Date \_\_\_ / \_\_\_ / \_\_\_