

**HEALTH HISTORY**

**PRESENT CONDITION**

**Please briefly describe your symptoms**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please localize your pain or abnormal symptoms/sensations by marking on the body diagram below**



**Pain scale**: 1 2 3 4 5 6 7 8 9 10

**When did you first notice symptoms?** \_\_\_\_\_\_\_\_\_\_\_

Did your symptoms begin **gradually** or **suddenly**?

 (circle one)

**How did your injury occur (if you have had surgery, please answer according to your pre-operative injury)**

* Lifting
* Car accident
* A fall
* Overuse
* Degenerative process
* During recreation/sports
* An impact injury
* Throwing
* Incident at work
* Unknown
* Running
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any recent/relevant surgeries or hospitalizations:**

Surgery/hospitalization Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Since the onset of your condition, are your symptoms getting:**

* Better
* Worse
* No change

**Have you experienced similar symptoms in the past?**

* Yes
* No

**More than one episode?**

* Yes
* No

**Nature of pain/symptoms**

* Aching
* Throbbing
* Periodic
* Dull
* Occasional
* Constant
* Other
* Sharp

**As your day progresses, do your symptoms**

* Increase
* Decrease
* Stay the same

**Does the pain wake you at night?**

* Yes
* No

**Since the onset of symptoms, have you experienced one of the following (check all that apply)**

* Fever or chills
* Numbness
* Any dizziness or fainting attacks
* Weakness
* Unexplained weight change (loss or gain)
* Night pain/sweats
* Malaise (vague feeling of bodily discomfort)
* Problems with vision/hearing

**What aggravates your symptoms?**

* Sitting
* Going to/rising from sitting
* Lying down
* Walking
* Up/down stairs
* Reaching overhead
* Reaching in front of body
* Reaching across body
* Talking, chewing, yawning
* Recreation or sports
* Repetitive activities
* Household activities
* Standing
* Squatting
* Sleeping
* Coughing/sneezing
* Taking a deep breath
* Looking up overhead
* Swallowing
* Stress
* Sustained bending
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What eases your symptoms?** (check all that apply)

* Sitting
* Heat
* Cold
* Stretching
* Wearing a split/orthotic
* Rest
* Standing
* Walking
* Exercise
* Lying down
* Massage
* Medication
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What type of treatment have you had for this condition?**

* Medication
* Joint manipulation
* Exercise
* Massage therapy
* Traction
* Bracing/taping
* Spinal injection
* Muscle/skin injections
* Chiropractor
* Physical therapy
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had any of the following tests for this condition?**

* X-ray
* CT Scan
* MRI
* Arthrogram
* Stress test x-ray
* Bone scan
* Nerve conduction test
* Fluoroscope
* Vestibular
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Test Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication**

**Please list any and all prescription medication you are currently taking for this condition:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you currently taking any of the following over the counter medications?**

* Aspirin
* Tylenol
* Corticosteroids
* Antihistamines
* Vitamins/mineral supplements
* Advil/Motrin/Ibuprofen
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL HEALTH**

**How would you rate your general health?**

* Excellent
* Good
* Average
* Fair
* Poor

**Do you exercise outside of normal daily activities?**

* 5+ days/week
* 3-4 days/week
* 1-2 days/week
* Occasionally
* I do not work out

**What kind of athletic or recreational activities do you perform?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you smoke?** \_\_\_\_\_\_\_\_\_\_\_

**Are you pregnant?**  \_\_\_\_\_\_\_\_\_\_ If so, how many months? \_\_\_\_\_\_

**MEDICAL HISTORY**

**Personal Medical History**

* Cancer
* Depression
* Lung problems
* High blood pressure
* Thyroid problems
* Epilepsy/seizures
* Multiple Sclerosis
* Mental/behavioral disorders
* Parkinson’s disease
* Stomach problems
* Circulation/vascular problems
* Heart conditions
* Stroke
* Diabetes
* Arthritis
* Allergies
* Head injury
* Rheumatoid
* Osteoporosis
* Fibromyalgia
* Broken bone
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you been exposed to**

* HIV/AIDS
* Tuberculosis
* Hepatitis

I, the undersigned, state that I have answered this health history completely and to the best of my knowledge:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date