

General Health Information

New patients and returning patients with a new injury/ concern must complete the following questionnaire

Patient Name: _____ Age: _____ Diagnosis or Problem Area: _____

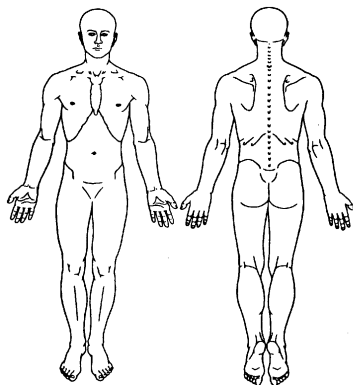
When did your pain begin? _____ Specific incident _____ Multiple incidents _____ Gradually developed _____ No specific incident

Describe the "incident(s)" above, or how the injury occurred: _____

Pain Diagram: Use the symbols below to mark the figures

Description:

- ^^ = Aching
- /// = Numbness
- >>> = Stabbing
- xxx = Burning
- 000 = Pins/ Needles
- +++ = Throbbing



Frequency:

- Sporadic (25% or less)
- Occasional (26-50%)
- Frequent (51-75%)
- Constant (76-100%)

Is the pain getting: Better Worse No Change

Have you had any of the following diagnostic tests for this injury?

- Bone Scan
- MRI
- X-Ray
- EMG/ Nerve Conduction Test
- CT Scan
- Other: _____

List your medications: _____

Please check as many of the following conditions that apply to you. Are you currently or have you ever experienced the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Stroke | <input type="checkbox"/> Numbness to Hands or Feet |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizures | <input type="checkbox"/> Visual/ Hearing Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blackouts | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High Blood Cholesterol (Hyperlipidemia) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Imbalance/ Frequent Falls | <input type="checkbox"/> Skin Rash/ Disease |
| <input type="checkbox"/> Bleeding/ Bruising Problem | <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV/ AIDS |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Sever Night Pain | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Difficulty Breathing/ Shortness of Breath | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bowel/ Bladder Problems |
| <input type="checkbox"/> Surgeries: _____ | <input type="checkbox"/> Orthopedic Injuries: _____ | |

Rate your pain from 0-10 as follows:

- | | | |
|---------------|------------------------------|-------------------------------|
| 0-1 No Pain | 4-5 Moderate/ Discomforting | 8-9 Intense/ Very Severe Pain |
| 2-3 Mild Pain | 6-7 Distressing/ Severe Pain | 10 Severe/ Unbearable |

Now: _____ **On average:** _____ **At its worst:** _____

What activities aggravate your injury/ problem area? _____

What activities relieve your injury/ problem area? _____

Is there any other information that you believe would assist the therapist in your care? _____

Patient Signature _____

Parent/ Guardian Signature _____

Date _____