

Patient Health Information

Name _____ Date ____/____/____

Please describe your current complaint or limitation:

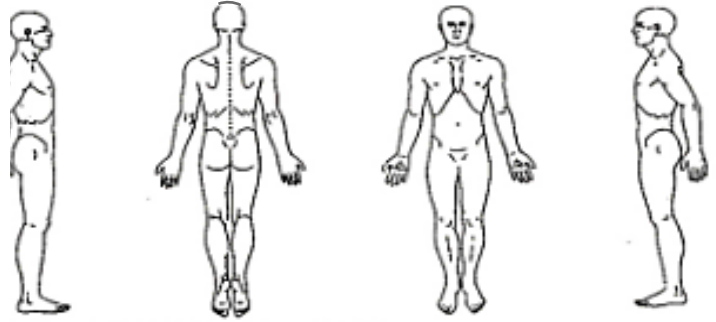
Please tell us when/how your problem began:

Did you have surgery? **No** **Yes** Date ____/____/____

Surgery Type: _____

Please circle the area of your pain on the body chart and check nature of below:

- | | |
|---|---|
| <input type="checkbox"/> Sharp pain | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Dull (pain) Ache | <input type="checkbox"/> Constant (76-100%) |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Frequent (51-75%) |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Occasional (26-50%) |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Intermittent (25- or less) |



Indicate the intensity of your pain at worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable pain)

Indicate the intensity of your pain currently: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable pain)

Indicate the intensity of your pain at best: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable pain)

Since this condition began your symptoms have: **decreased** **not changed** **increased**

Your symptoms are worse (*circle one*) **morning** -- **afternoon** -- **night** --- **increased during the day**--- **same all day**

In the past have you been treated for this problem: **Yes** **No**

If yes, who did you see for this condition? **MD** **PT** **OT** **Chiropractor** **Other** _____

When and what treatment did you receive? _____

Occupation: _____ Has your work status changed because of this condition: **Yes** or **No**

The information you provide concerning past & present conditions and diseases assists your therapist in more thoroughly understanding your state of health

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain/TMJ
<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition
<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Nervous System Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cancer location: _____ date _____
<input type="checkbox"/>	<input type="checkbox"/>	Tumor
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizure
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco packs/day _____
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

Hospitalizations/Surgical Procedures/Previous Injuries (if not elsewhere stated) _____

I have reviewed contradictions with the patient prior to initiating evaluation and treatment. The following contradictions were identified:

I have reviewed with the patient their rehabilitation potential prior to initiating treatment.

Patient/Guardian Signature Date

Therapist Signature Date