Patient History

Name _____ **Age**_____ **(DOB)**_____ **Date**_____

1. Describe the current problem that brought you here?_____

_____

2. When did your problem first begin (timeline)? _____

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____

_____

4. Since that time is it: staying the _____ same _____ getting worse _____getting better
Why or how?_____

5. Have your had symptoms or pain like this in the past? _____If YES please describe: _____

_____

6. Describe previous treatment/exercises_____

_____

7. Activities/events that cause or aggravate your symptoms. Check/circle all that apply

___ Sitting greater than___ ___minutes
___ Walking greater than _____minutes
___ Standing greater than _____ minutes
___ Changing positions (ie. - sit to stand)
___ Light activity (light housework)
___ Vigorous activity/exercise (run/weight lift/jump)
___ Sexual activity
___ Other, please list _____

___ With cough/sneeze/straining
___ With laughing/yelling
___ With lifting/bending
___ With cold weather
___ With triggers -running water/key in door
___ With nervousness/anxiety/stress
___ No activity affects the problem

8. What relieves your symptoms?_____

_____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____
Other _____

10. Rate the severity of this problem from 0 -10 with 0 being no problem and 10 being the worst _____

11. What are your treatment goals?_____

_____

Since the onset of your current symptoms have you had:

Y/N	Fever/Chills	Y/N	Malaise (Unexplained tiredness)
Y/N	Unexplained weight change	Y/N	Unexplained muscle weakness
Y/N	Dizziness or fainting	Y/N	Night pain/sweats
Y/N	Change in bowel or bladder functions	Y/N	Numbness / Tingling

Y/N Other /describe_____

_____

Name_____ **(DOB)**_____

Health History: Date of Last Physical Exam _____ Tests performed_____

General Health: Excellent Good Average Fair Poor Occupation _____
Hours/week_____ On disability or leave?_____ Activity Restrictions? _____
Mental Health: Current level of stress High_____ Med___ Low___ Current psych therapy? Y/N
Activity/Exercise: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____

Have you ever had any of the following conditions or diagnoses? circle all that apply /describe

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe_____

Surgical /Procedure History

Y/N	Surgery for your back/spine	Y/N	Surgery for your bladder/prostate
Y/N	Surgery for your brain	Y/N	Surgery for your bones/joints
Y/N	Surgery for your female/male organs	Y/N	Surgery for your abdominal organs

Other/describe_____

Ob/Gyn History (females only)

Y/N	Childbirth vaginal deliveries #_____	Y/N	Vaginal dryness
Y/N	Episiotomy #_____	Y/N	Painful periods
Y/N	C-Section #_____	Y/N	Menopause - when? _____
Y/N	Difficult childbirth #_____	Y/N	Painful vaginal penetration
Y/N	Prolapse or organ falling out	Y/N	Pelvic pain
Y/N	Currently Pregnant	Y/N	Attempting to get Pregnant
Y/N	Other /describe_____		

Males only

Y/N	Prostate disorders	Y/N	Erectile dysfunction
Y/N	Shy bladder	Y/N	Painful ejaculation
Y/N	Pelvic pain		
Y/N	Other /describe_____		

Medications - pills, injection, patch	Start date	Reason for taking

Over the counter -vitamins etc	Start date	Reason for taking

(Please provide printed list of meds and supplements if more space needed/ if available)

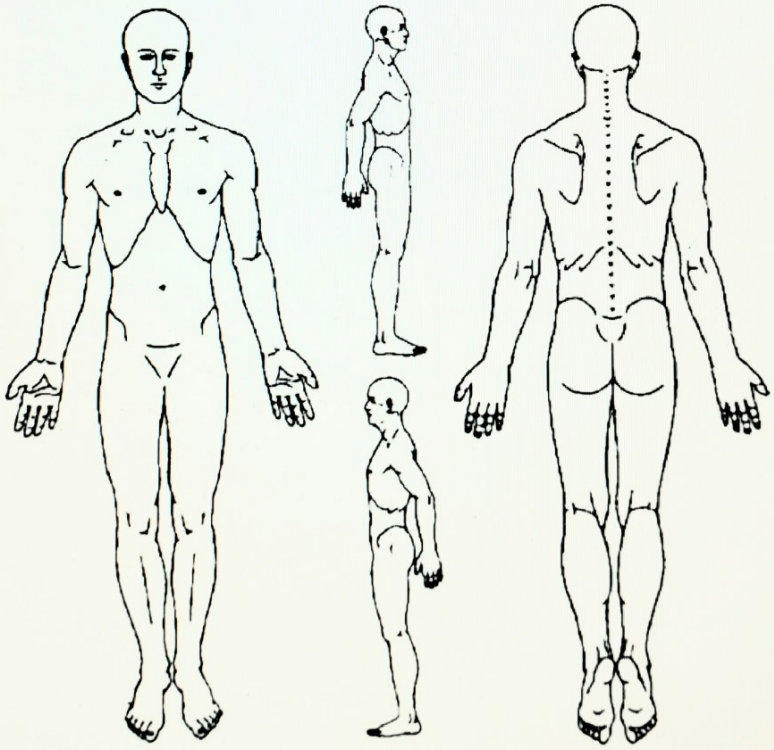
Name_____(DOB)_____

On a Scale 0/10 (0 being no pain and 10 being emergency room pain)
What is your Current pain_____ Worst Pain_____ Best Pain _____

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^ ^	X X X X	⊗ ⊗ ⊗ ⊗



What do You Believe is Going On?

_____
_____

Why did this happen?

_____
_____

What are your Expectations? (What is a good Outcome?)

_____
_____

What Are Your Concerns? (What is your greatest fear(s) with regard to this?)

_____
_____