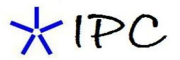


HEALTH HISTORY



Patient Name: _____ Date: ____/____/____

List and describe any new or continuing pain conditions: _____

Clinicians treating you for this condition: _____ Phone: () _____

Date of initial onset for this condition: _____ If reoccurrence, date of current aggravation: _____

Describe how the injury occurred: _____

When did your problem begin? Immediately after a specific incident Multiple incidents Gradually developed

No specific incident - Please list the "incident/s": _____

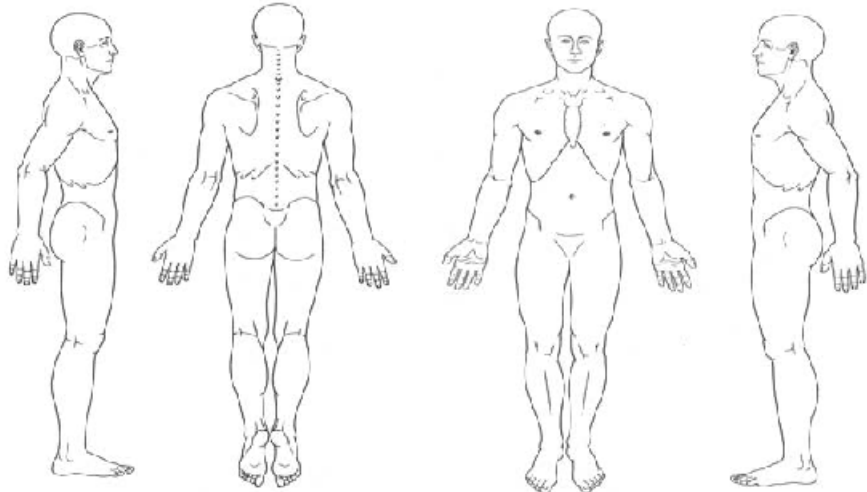
Pain Diagram: Use symbols below to mark the figures.

Description:

- XXX = Aching
- /// = Numbness
- >>> = Stabbing
- ### = Burning
- 000 = Pins/Needles
- TTT = Throbbing

Frequency (overall):

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



Rate Intensity as Follows (This Section):

- | | | |
|------------------------------|------------------------------------|---|
| 0 None | 4 Moderate, bothers during | 8 Intense, preoccupied, seeks |
| 1 Maybe | work/activities | relief instead of activity |
| 2 Mild, forgotten w/activity | 6 Limiting, prevents full activity | 10 Severe—on bed rest, stops all activity |

Complaint (I.e. Neck Pain, Low Back Pain, etc)	Place "X" for average pain, "O" worst pain, "□" pain now	Is it getting		
		Better	Worse	No Change
1. _____	0....1....2....3....4....5....6....7....8....9....10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. _____	0....1....2....3....4....5....6....7....8....9....10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. _____	0....1....2....3....4....5....6....7....8....9....10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. _____	0....1....2....3....4....5....6....7....8....9....10	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any recent treatment (medication, therapy, injections) helpful in decreasing your pain: Meds Therapy Procedures Other

Your general stress level: No stress Minimal stress Moderate stress Greatly stressed

Physical activity at work: Sitting more than 50% of day Light manual labor Manual labor Heavy manual labor

General physical activity: No regular exercise program Light exercise program Strenuous exercise program

Please describe your level of function with current treatment: _____

Please describe any other physical/emotional/hormonal medical concerns: _____

Patient signature _____

Date _____

HEALTH HISTORY



Patient Name _____ Date _____

1. What time of the day are your symptoms worse?

- (1) Morning
- (2) Afternoon
- (3) Evening
- (4) During Sleep
- (5) None of the above (constant pain)

2. What makes your pain better?

- (1) Rest
- (2) Ice or Heat (Please circle one)
- (3) Prescription medications
- (4) Interventional Injections
- (5) Other: _____

3. What makes your pain worse?

- (1) Activity (work, repetitive motions, etc.)
- (2) Ice or Heat (Please circle one)
- (3) Sitting
- (4) Standing
- (5) Laying
- (6) Other: _____

4. Does your pain wake you at night?

- (1) Yes
- (2) No

5. Do you experience any weakness in the area of your pain or other body regions?

6. Do you experience any change in sensation in the area of your pain?

7. Do you experience any radiation of your pain into other areas of your body?



Review of Systems Worksheet

Patient Name: _____ Date: _____

Please check all that apply to you:

1. General

- No problems
- Fever or chills
- Unexplained hair loss (alopecia)

2. Eyes

- No problems
- Vision problems (blurred vision, loss of vision)
- Eye pain

3. Ears/Nose/Mouth/Throat

- No problems
- Dizziness
- Dental problems
- Swollen glands in neck
- Sore throat/pain when swallowing
- Mouth sores

4. Cardiovascular

- No problems
- Chest pain (sharp, crushing, or heaviness)
- Heart racing (palpitations)
- Sudden shortness of breath at night or lying down
- Leg pain in calf or thigh of leg
- Aching/Burning in legs
- Fainting spells
- Swelling of legs (Edema)

5. Respiratory

- No problems
- Shortness of breath
- Night sweats
- Cough/coughing up blood

6. Gastrointestinal

- No problems
- Decreased appetite
- Nausea/Vomiting
- Constipation
- Increased appetite
- Stomach pain
- Diarrhea

7. Genitourinary

Men and Women:

- No problems
- Pain when passing water (urination)
- Passing water more than usual (day and/or night)
- Pain during sex
- Sores (vagina, penis, rectum)
- Blood in urine
- Bladder Infection/other infections
- Changes in sex drive (libido)

Women:

- Irregular periods (menstruation)
- Increased or too little bleeding during periods (menstruation)
- Three or more yeast infections in a year
- Painful periods (menstruation)
- Discharge from vagina

Men:

- Discharge from penis (drip)
- Swelling in balls (scrotum)

8. Musculoskeletal

- No problems
- Joint pain
- Numbness, tingling, or weakness in arms or legs
- Limited motion of arms or legs
- Swelling/Redness If so, where _____
- Pain in calf or thigh

