Current History

Patient Name: _____ Date: _____

1. On what date were you injured and/or what date did you have surgery? _____

Give a description of your injury, history of your current problem and/or any past surgeries or injuries to the area we are seeing you for:

2. What are your primary symptoms for the injured area? (**Check ALL That Apply**)

- o Pain
- o Weakness
- o Stiffness
- o Popping
- o Instability
- o Swelling
- o Numbness/Tingling
- o Other _____

3. Are you presently working?

- o Yes, **without** restrictions
- o Yes, **with** restrictions
- o No, not working presently
- o Retired

Job Title: _____ Job Description: _____

4. What are the most important goals that you would like to accomplish throughout your time in therapy? _____

_____

_____

Medical History

Check **ALL** That Apply

- o No Known Medical History to Affect Treatment
- o Alzheimer's
- o Cardiovascular Disease
- o Current Infection
- o Diabetes Mellitus Type I
- o Diabetes Mellitus Type II
- o Fibromyalgia
- o Fracture
- o High Blood Pressure
- o History of Cancer _____
- o Immunosuppressant
- o Lupus
- o Osteoarthritis
- o Pacemaker
- o Rheumatoid Arthritis
- o Other (Describe Below) _____

_____

Allergies: _____

Surgical History: _____

_____

Current Medications: _____

_____

_____

Symptom Assessment

1. Do you wake up at night with pain?

   - o Yes
   - o No

2. How often do you wake at night because of the injury/ surgery? _____

3. What activities or movements make your pain worse? _____

4. What activities or movements alleviate your pain? _____

5. On a scale of 0-10 (**ZERO** being **NO** pain and **TEN** being **EMERGENCY ROOM** pain) please indicate on the scale the amount of pain you are in **RIGHT NOW:**

NO PAIN 0----1----2----3----4----5----6----7----8----9----10 SEVERE PAIN

On the diagram below please circle or shade the area where your symptoms are affecting you: