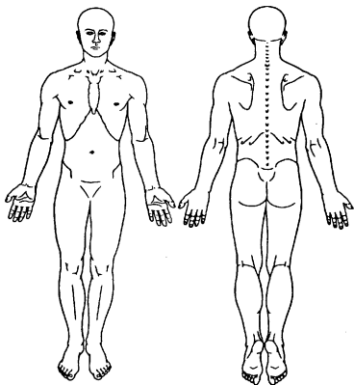
General Health Information

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

Patient Name: _____ Age: _____ Weight: _____ Height: _____
Diagnosis or Problem Area: _____
When did your pain begin? _____ Specific incident ____ Multiple incidents ____ Gradually developed ____ Unknown _____
Describe the "incident(s)" above, or how the injury occurred: _____
_____

Pain Diagram: Use the symbols below to mark the figures

Description:
^^^ = Aching/ Dull
/// = Numbness
>>> = Stabbing/ Sharp
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 all current medications:
_____
_____
_____
_____
_____
_____
_____

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

❑Alzheimer's/ Dementia
❑Brain or head injury
❑ Cardiovascular disease
❑Cerebrovascular Accident/ Stroke
❑Current infection
❑Diabetes Type 1/ Type 2
❑Dizziness
❑Fibromyalgia
❑Fracture or suspected fracture
❑High blood cholesterol
❑High blood pressure
❑Low blood pressure
❑History of cancer. Type: _____
❑Imbalance/ Falls
❑Obesity
❑Osteoarthritis
❑Osteoporosis/ osteopenia
❑Other: _____
❑Paresthesias into the extremities
❑Pregnancy
❑Rheumatoid arthritis
❑Severe night pain
❑Tobacco use
❑Unexplained weight loss/ gain
❑Unexplained change in bowel/ bladder function
❑Visual or hearing problems

❑Surgeries: _____ ❑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: _____ At its best: _____ At its worst: _____

What activities aggravate your injury/ problem area? _____
What activities relieve your injury/ problem area? _____
Any other information that you believe would assist the therapist in your care? _____
_____

_____ _____ _____
Patient Signature Parent/ Guardian Signature Date