



Patient History

Name: _____ Age: _____ Date of Onset: _____

Occupation: _____ Are you working? Y/N

Describe the current problem that brought you here: _____

Is the pain staying the same, getting worse or getting better? _____

If pain is present - rate pain on a 0-10 scale with 10 being the worst. _____

Describe the pain (ex: constant, comes and goes, etc.) _____

Describe previous treatment or exercises: _____

What relieves your symptoms? _____

What activities aggravate your symptoms? Check/circle all that apply:

- | | |
|---|--|
| <input type="checkbox"/> Sitting greater than _____ minutes | <input type="checkbox"/> With Cough/Sneeze/Straining |
| <input type="checkbox"/> Standing greater than _____ minutes | <input type="checkbox"/> With Lifting/Bending |
| <input type="checkbox"/> Walking greater than _____ minutes | <input type="checkbox"/> With Cold Weather |
| <input type="checkbox"/> Changing positions (sit to stand) | <input type="checkbox"/> With anxiety |
| <input type="checkbox"/> Light Housework | <input type="checkbox"/> Sexual Activity |
| <input type="checkbox"/> Vigorous exercise (running, jumping, weight lifting) | <input type="checkbox"/> No activity affects the problem |
| <input type="checkbox"/> Sleeping | |
| <input type="checkbox"/> Other _____ | |

Since the onset of your current symptoms have you had?

- | | | | |
|-----|--------------------------------------|-----|-----------------------------|
| Y/N | Fever Chills | Y/N | Unexplained Tiredness |
| Y/N | Unexplained weight change | Y/N | Unexplained Muscle Weakness |
| Y/N | Dizziness/Fainting | Y/N | Night pain/sweats |
| Y/N | Change in bladder or bowel functions | Y/N | Numbness/Tingling |

Are you taking any medications? Y/N: If yes, please list:

Current Level of Stress: High _____ Medium _____ Low _____



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

| | | | | | |
|-------------------------------------|----------------------------|-------------------------------------|--------------------------|-------------------------------------|------------------------------|
| <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> | |
| | Cancer | | Stroke | | Emphysema |
| | Heart Problems | | Seizures | | Asthma |
| | High Blood Pressure | | Multiple Sclerosis (MS) | | Latex Sensitivity |
| | Anemia | | Head Injury | | Thyroid: Hypo/Hyper |
| | Low Back Pain | | Osteoporosis | | Headaches |
| | Sacroiliac/Tailbone Pain | | Chronic Fatigue Syndrome | | Diabetes |
| | Arthritic Conditions | | Kidney Disease | | Lyme Disease |
| | Childhood Bladder Problems | | Stress Fractures | | Irritable Bowel Syndrome |
| | Depression | | Rheumatoid Arthritis | | Hepatitis |
| | Eating Disorders | | Joint Replacement | | HIV/AIDS |
| | TMJ/neck pain | | Pelvic Pain | | Raynauds (cold hands & feet) |
| | Hearing Loss | | Vision Problems | | Adhesive Tape Allergies |
| | Pacemaker | | Urinary Tract Infection | | Incontinence (Urinary/bowel) |

Please list any operations (with date) that you have received in your lifetime.

| Operation | Date |
|-----------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |