





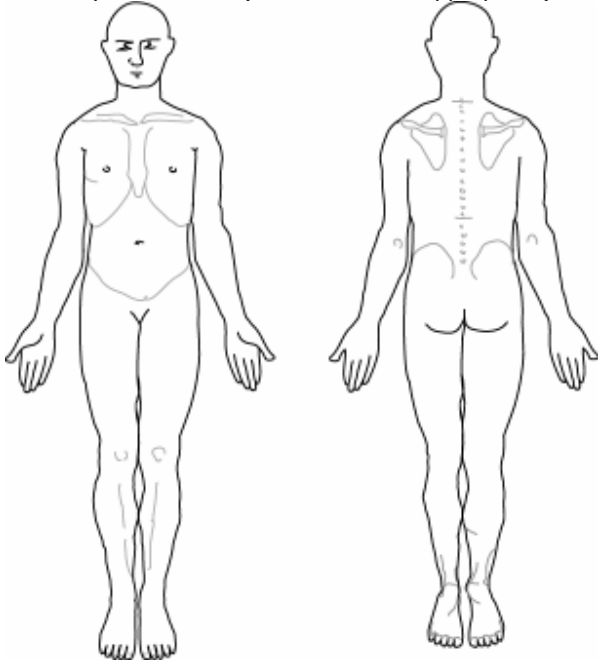
**NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

*To insure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.*

**HISTORY OF PRESENT CONDITION**

1. What are your symptoms? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Localize areas of **pain** or **abnormal** sensation on the body chart below (Shade in where appropriate)



2. When did your symptoms begin?  
(Please indicate a specific date if possible) \_\_\_\_\_

3. Was the **onset** of this episode gradual or sudden?(Check one)  
 (1) gradual  (2) sudden

4. Which of the following **best describes** how your injury occurred? (if your condition is post-surgical please indicate as per original injury)

<input type="checkbox"/> (1) lifting	<input type="checkbox"/> (9) a blow to the face
<input type="checkbox"/> (2) a MVA (car accident)	<input type="checkbox"/> (10) being hit by a ball
<input type="checkbox"/> (3) a fall	<input type="checkbox"/> (11) a dental appointment
<input type="checkbox"/> (4) overuse (cumulative trauma)	<input type="checkbox"/> (12) throwing
<input type="checkbox"/> (5) trauma	<input type="checkbox"/> (13) an incident at work
<input type="checkbox"/> (6) degenerative process	<input type="checkbox"/> (14) unknown
<input type="checkbox"/> (7) during recreation/sports	<input type="checkbox"/> (15) other _____
<input type="checkbox"/> (8) running	

5. Since onset, are your symptoms getting: (Check one)  
 (1) better  (2) worse  (3) not changing

6. Have you had similar symptoms in the past? (1)  Yes (2)  No  
More than one episode? (1)  Yes (2)  No

7. Nature of pain/symptoms (check all that apply)

<input type="checkbox"/> (1) sharp	<input type="checkbox"/> (4) aching	<input type="checkbox"/> (7) constant
<input type="checkbox"/> (2) dull	<input type="checkbox"/> (5) periodic	<input type="checkbox"/> (8) other _____
<input type="checkbox"/> (3) throbbing	<input type="checkbox"/> (6) occasional	

8. As the day progresses, do your symptoms: (Check one)  
 (1) increase  (2) decrease  (3) stay the same

9. Does the pain wake you at night?  (1) No  (2) Yes  
if "yes", is it present  (1) while lying still  
 (2) only when changing positions  
 (3) both

10. Do you have pain/stiffness upon getting out of bed in the morning?  (1) Yes  (2) No

11. In what position do you sleep? (Check all that apply)

<input type="checkbox"/> (1) right side	<input type="checkbox"/> (4) back	<input type="checkbox"/> (6) back, sides, stomach
<input type="checkbox"/> (2) left side	<input type="checkbox"/> (5) chair/recliner	<input type="checkbox"/> (7) other _____
<input type="checkbox"/> (3) stomach		

12. Since the onset of your current symptoms have you had:

- (1) any difficulty with control of bowel or bladder function
- (2) fever/Chills
- (3) any numbness in the genital or anal area
- (4) numbness
- (5) any dizziness or fainting attacks
- (6) weakness
- (7) unexplained weight change
- (8) night pain/sweats
- (9) malaise (vague feeling of bodily discomfort)
- (10) problems with vision/hearing
- (11) none of the above

13. What aggravates your symptoms? (Check all that apply)

<input type="checkbox"/> (1) sitting	<input type="checkbox"/> (9) repetitive activities
<input type="checkbox"/> (2) going to/rising from sitting	including _____
<input type="checkbox"/> (3) lying down	<input type="checkbox"/> (10) household activities
<input type="checkbox"/> (4) walking	including _____
<input type="checkbox"/> (5) up/down stairs	<input type="checkbox"/> (11) standing
<input type="checkbox"/> (6) reaching overhead	<input type="checkbox"/> (12) squatting
<input type="checkbox"/> (6) reaching in front of body	<input type="checkbox"/> (13) sleeping
<input type="checkbox"/> (6) reaching behind back	<input type="checkbox"/> (14) coughing/sneezing
<input type="checkbox"/> (6) reaching across body	<input type="checkbox"/> (15) taking a deep breath
<input type="checkbox"/> (7) talking, chewing, yawning, all ( <i>circle one</i> )	<input type="checkbox"/> (16) looking up overhead
<input type="checkbox"/> (8) recreation/sports including _____	<input type="checkbox"/> (17) swallowing
	<input type="checkbox"/> (18) stress
	<input type="checkbox"/> (19) sustained bending
	<input type="checkbox"/> (20) other _____

14. What relieves your symptoms? (Check all that apply)

<input type="checkbox"/> (1) sitting	<input type="checkbox"/> (6) rest	<input type="checkbox"/> (11) massage
<input type="checkbox"/> (2) heat	<input type="checkbox"/> (7) standing	<input type="checkbox"/> (12) medication
<input type="checkbox"/> (3) cold	<input type="checkbox"/> (8) walking	<input type="checkbox"/> (13) nothing
<input type="checkbox"/> (4) stretching	<input type="checkbox"/> (9) exercise	<input type="checkbox"/> (14) other _____
<input type="checkbox"/> (5) wearing a splint/orthosis	<input type="checkbox"/> (10) lying down	

15. Have you had any previous treatment for this condition?  
(Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> (1) none                            | <input type="checkbox"/> (11) hypnosis                  |
| <input type="checkbox"/> (2) medication (oral)               | <input type="checkbox"/> (12) biofeedback               |
| <input type="checkbox"/> (3) joint manipulation              | <input type="checkbox"/> (13) TENS unit                 |
| <input type="checkbox"/> (4) exercise                        | <input type="checkbox"/> (14) acupuncture               |
| <input type="checkbox"/> (5) massage therapy                 | <input type="checkbox"/> (15) bed rest                  |
| <input type="checkbox"/> (6) traction                        | <input type="checkbox"/> (16) overnight hospitalization |
| <input type="checkbox"/> (7) bracing/taping                  | <input type="checkbox"/> (17) casting                   |
| <input type="checkbox"/> (8) injection into the spine        | <input type="checkbox"/> (18) other _____               |
| <input type="checkbox"/> (9) injection into the skin/muscles |   |
| <input type="checkbox"/> (10) physical therapy               |   |

16. Have you had any of the following tests?

- |  |   |
|--|---|
| <input type="checkbox"/> (1) none                      | <input type="checkbox"/> (7) Bone Scan    |
| <input type="checkbox"/> (2) x-rays                    | <input type="checkbox"/> (8) NCS          |
| <input type="checkbox"/> (3) CT Scan                   | <input type="checkbox"/> (9) Fluoroscope  |
| <input type="checkbox"/> (4) MRI                       | <input type="checkbox"/> (10) Vestibular  |
| <input type="checkbox"/> (5) Arthrogram                | <input type="checkbox"/> (11) other _____ |
| <input type="checkbox"/> (6) Stress X-ray Test (Telos) |   |
- Test Results: \_\_\_\_\_

### MEDICATION

Please list any prescription medications you are currently taking  
(*pain pills, injections and/or skin patches, etc.*):

Prescribing MD: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you currently taking any of the following over the counter medications?

- |   |   |
|---|---|
| <input type="checkbox"/> (1) aspirin                      | <input type="checkbox"/> (6) Advil/Motrin/<br>Ibuprofen |
| <input type="checkbox"/> (2) Tylenol                      | <input type="checkbox"/> (7) other _____                |
| <input type="checkbox"/> (3) corticosteroids              |   |
| <input type="checkbox"/> (4) antihistamines               |   |
| <input type="checkbox"/> (5) vitamins/mineral supplements |   |

### PREVIOUS FUNCTIONAL LEVEL

**Independent in all activities** (work, community, home, recreation)

#### Self-care

- Independent in all self-care activities (bathing, toileting, dressing, etc.)
- Difficulty performing self-care activities
- Need assistance with self-care activities
- Difficulty performing household chores

#### Social

- Need assistance with activities in community outside of home

**Hobbies:** \_\_\_\_\_

### WORK HISTORY

#### Occupation

- |   |  |
|---|--|
| <input type="checkbox"/> (1) employed full time | <input type="checkbox"/> (5) student     |
| <input type="checkbox"/> (2) employed part time | <input type="checkbox"/> (6) retired     |
| <input type="checkbox"/> (3) self employed      | <input type="checkbox"/> (7) unemployed  |
| <input type="checkbox"/> (4) homemaker          | <input type="checkbox"/> (8) other _____ |

**Physical activities at work** (check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> (1) sitting            | <input type="checkbox"/> (6) computer use              |
| <input type="checkbox"/> (2) standing           | <input type="checkbox"/> (7) heavy equipment operation |
| <input type="checkbox"/> (3) phone use          | <input type="checkbox"/> (8) driving                   |
| <input type="checkbox"/> (4) repetitive lifting | <input type="checkbox"/> (9) other _____               |
| <input type="checkbox"/> (5) heavy lifting      |  |

Are you currently receiving or seeking disability for this condition?  (1) Yes  (2) No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?

- (1) Yes  (2) No

### LIVING SITUATION

- |  |  |
|--|--|
| <input type="checkbox"/> (1) live alone                      | <input type="checkbox"/> (6) assisted living complex |
| <input type="checkbox"/> (2) live with family members/others | <input type="checkbox"/> (7) other _____             |
| <input type="checkbox"/> (3) live with caregiver             |  |
| <input type="checkbox"/> (4) home/apartment                  |  |
| <input type="checkbox"/> (5) retirement complex (SNF/ICF)    |  |

#### Setting

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> (1) stairs (railing)    | <input type="checkbox"/> (3) no stairs | <input type="checkbox"/> (6) uneven ground |
| <input type="checkbox"/> (2) stairs (no railing) | <input type="checkbox"/> (4) ramp      | <input type="checkbox"/> (7) other _____   |
|  | <input type="checkbox"/> (5) elevator  |  |

### GENERAL HEALTH

How would you rate your general health?

- |                                    |                                  |                               |
|------------------------------------|----------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Average | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Good      | <input type="checkbox"/> Fair    |                               |

Do you exercise outside of normal daily activities?

- |                                      |                                       |                               |
|--------------------------------------|---------------------------------------|-------------------------------|
| <input type="checkbox"/> 5+ days/wk  | <input type="checkbox"/> 1-2 days/wk  | <input type="checkbox"/> zero |
| <input type="checkbox"/> 3-4 days/wk | <input type="checkbox"/> occasionally |                               |
- Exercise, Sports/Recreation consisting of \_\_\_\_\_

Do you drink caffeinated beverages?

- No  Yes How many/much per day \_\_\_\_\_

Do you smoke?

- No  Yes Packs of cigarettes per day \_\_\_\_\_

What is your stress level?

- Low  Medium  High

Are you seeing any health care providers other than the physical therapist for this current condition? (Please list) \_\_\_\_\_

### PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)

- |   |  |
|---|--|
| <input type="checkbox"/> Cancer (type) _____                                      | <input type="checkbox"/> Heart problems                |
| <input type="checkbox"/> Depression   | <input type="checkbox"/> High blood pressure           |
| <input type="checkbox"/> Stroke   | <input type="checkbox"/> Lung problems                 |
| <input type="checkbox"/> Kidney problems  | <input type="checkbox"/> Blood disorders               |
| <input type="checkbox"/> Thyroid problems   | <input type="checkbox"/> Epilepsy/seizures             |
| <input type="checkbox"/> Diabetes   | <input type="checkbox"/> Allergies                     |
| <input type="checkbox"/> Multiple sclerosis                                       | <input type="checkbox"/> Rheumatoid arthritis          |
| <input type="checkbox"/> Arthritis  | <input type="checkbox"/> Osteoporosis                  |
| <input type="checkbox"/> Head injury  | <input type="checkbox"/> Broken bone                   |
| <input type="checkbox"/> Stomach problems   | <input type="checkbox"/> Circulation/vascular problems |
| <input type="checkbox"/> Parkinson's disease                                      | <input type="checkbox"/> Other _____                   |
| <input type="checkbox"/> Infectious diseases (i.e. hepatitis, tuberculosis, etc.) |  |

Please list any recent/relevant past surgeries related to your current problem:

<b>SURGERY</b>	<b>DATE</b>
_____	_____
_____	_____

### FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated of any of the following?

- |  |  |
|--|--|
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Cancer                  |
| <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Arthritis               |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis            |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Psychological condition |
| <input type="checkbox"/> Other _____         |  |