PATIENT SELF HISTORY

DATE:______________________

PATIENT NAME:____DATE OF BIRTH:_____________________

MEDICAL HISTORY

Do you have, or have you ever had any of the following? Please explain.

Heart Problems	yes ____no_____	____________________
Lung Problems	yes ____no_____	____________________
High blood pressure	yes ____no_____	____________________
Surgeries	yes ____no_____	____________________
Pregnancies, how many?	yes ____no_____	____________________
Recent weight loss	yes ____no_____	____________________
Diabetes	yes ____no_____	____________________
Cancer	yes ____no_____	____________________
Colitis or ulcer	yes ____no_____	____________________
Bowel / bladder problems	yes ____no_____	____________________
Asthma	yes ____no_____	____________________
Arthritis	yes ____no_____	____________________
Osteoporosis	yes ____no_____	____________________
Brittle bones	yes ____no_____	____________________

Do you have any other major illnesses, diseases or allergies? ____________________

Current diagnosis________________________How long have you had present pain?______________

List current medications____________________________________

____

Did your pain begin gradually, suddenly, or with injury?____________________

Is your pain continuous or on/off? Describe your pain.____________________

Did you feel a “pop” when the pain began?____________________

Do you have any other weakness, numbness, or tingling? If so, where?____________________

Do you exercise on a regular basis? If so, how often and what type of exercise?____________________

____

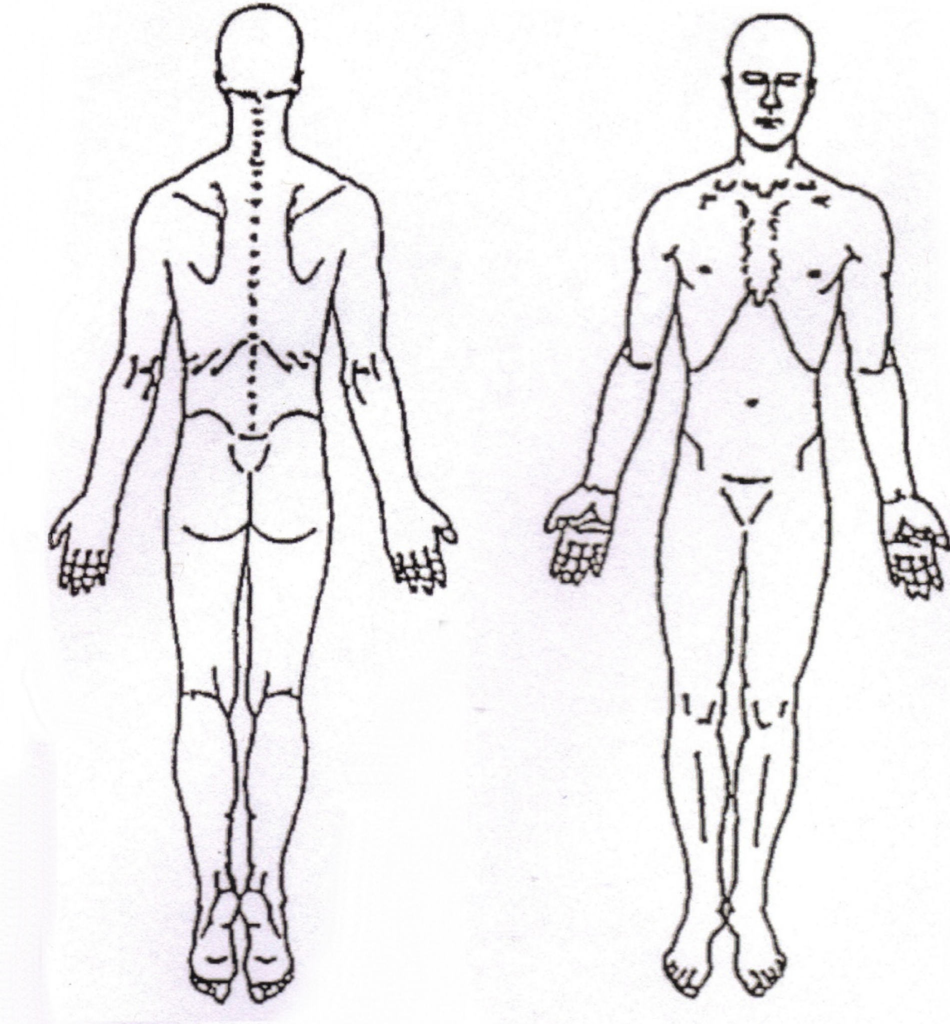
Goals you wish to achieve through therapy____________________________________

____

PATIENT NAME:____DOB:________________________

Mark on the figures where you feel the described sensations. Please use the appropriate symbols listed.

Numbness =====   Burning XXXXX   Stabbing //////   Pins and Needles 00000   Dull Ache ------



If "0" represents no pain and "10" represents unbearable pain, please rate your pain.

At its worse ______________

At its best ______________

Most of the time______________

Today ______________

Of "0%" = cannot complete basic activities and 100% = Independent with all activities, how limited are you?

0%   20%   40%   60%   80%   100%

____   ____

Patients Signature   Date: