Patient History

Patient Name_________________________ **DOB** ______________ **Date** ______________

Describe the current problem that brought you here?____

____

When did your problem first begin? _______ months agoor ______ years ago.

Was your first episode of the problem related to a specific incident? Yes / No

Please describe and specify date ____

____

Since that time is it: staying the same ________ getting worse ________ getting better __________

Why or how? ____

What are your treatment goals/concerns? ____

____

If pain is present, rate pain on a 0-10 scale 10 being the worst ______________Describe the nature of the pain (i.e. constant burning, intermittent ache) ____

____

Describe previous treatment/exercises ____

____

Activities/events that cause or aggravate your symptoms. Check/circle all that apply:

____ Sitting greater than ____ minutes

____ Walking greater than ____ minutes

____ Standing greater than ____ minutes

____ Changing positions (i.e. sit to stand)

____ Light activity (light housework)

____ Vigorous activity/exercise (run/weight lift/jump)

____ Sexual activity

____ With laughing/yelling

____ With cough/sneeze/straining

____ With lifting/bending

____ With cold weather

____ With triggers (running water/key in the door)

____ With nervousness/anxiety

____ No activity affects the problem

____ Other, please list ____

____

What relieves your symptoms?____

____

How has your lifestyle/quality of life been altered/changed because of this problem?

Social activities (exclude physical activities), specify____

Diet/Fluid intake, specify____

Physical activity, specify ____

Work, specify____

Other ____

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