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IMPAIRMENTS, DYSFUNCTION & HISTORY

In order to help me understand your condition I am asking you some questions about your body that may be hard to put into words. Please *circle* what applies AND provide as much *specific detail* as possible.

Name _____ **Injury Date** _____ **Surgery Date** _____

If no date, when did you first notice symptoms? _____

HOW did your injury/condition occur? _____

_____

_____

Is your injury related to? Work Auto Sports Falling Surgery Other _____

Do you have any diagnostic scans available? (i.e. x-ray, MRI, etc.) _____

Have you experienced this injury/condition in the past? Yes No

If YES, how often? _____

Year of first episode: _____

Previous treatment: _____

WHAT hurts and DOES your pain travel/radiate? _____

_____

_____

DESCRIBE your pain: Burning Throbbing Sharp Dull Achy Shooting
Numb Tingly Stiff Constant Intermittent
Unusual weakness Unusual Incoordination Spasms

RATE your pain intensity on a scale of 0 to 10, with "0" as no pain, "7" makes you cry, "10" takes you to the hospital: At Worst _____ Currently _____ At Best _____

WHAT is the progression of your pain pattern? Improving Worsening Remaining the same

IF your pain is not improving, why do you think symptoms are persisting? _____

_____

Once aggravated, how long does it take before your pain reduces? _____

WHAT is your daily pain pattern? Morning: _____
Afternoon: _____
Evening: _____
Night: _____

HOW can you make your pain WORSE? Sitting Standing Sit to stand Lying down
Bending Turning Squatting Stairs up/down Cough/sneeze Voiding
Driving Walking Household Activities Reaching Pushing Pulling Lifting
Carrying Community integration/access When still When moving Sleeping
Other: _____

HOW can you make your pain BETTER? Sitting Standing Sit to stand Lying down
Bending Turning Squatting Stairs up/down Cough/sneeze Voiding
Driving Walking Household Activities Reaching Pushing Pulling Lifting
Carrying Community integration/access When still When moving Sleeping
Other: _____

How has your injury/condition changed your life? Please be as specific as possible.

Work **Prior:** _____
Current: _____

Sleep **Prior:** _____
Current: _____

Fitness **Prior:** _____
Current: _____

Hobbies **Prior:** _____
Current: _____

Socialization **Prior:** _____
Current: _____

How do you cope with your pain when it flares? _____

Do you have any fear about your injury/condition? If YES, what? _____

Do you think your condition will improve? If NO, why? _____

Do you have social (family, friend) support during this time? _____

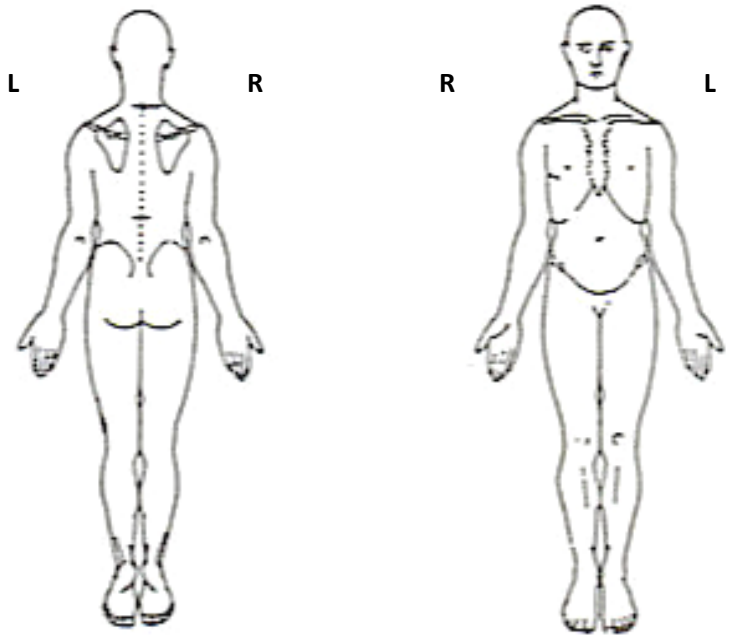
What was your average stress level PRIOR to your injury? Low Medium High

What is your average stress level SINCE your injury? Low Medium High

What are your GOALS for Physical Therapy? _____

Please indicate location(s) of your injury on the images using the following key:

Pain XXXXXX Numbness OOOOO
Tingling ###### Burning //////////



Are you currently treating with other Medical Providers for your current condition? Yes No

If YES please report Name(s) & Profession(s): _____

_____

_____

General Health: Excellent Good Average Fair Poor

Number of alcoholic beverages / week? _____ **Number of cigarettes / week?** _____

Please list any major SURGERIES and approximate dates		**Please list or provide a list of your current MEDICATIONS and dosages**	

Do you have a history of any of the following: (please circle)

Nervous System: Dizziness Stroke Epilepsy/Seizures Multiple Sclerosis
Concussion Polio Parkinson's Disease Visual Changes
Fainting Other: _____

Musculoskeletal: Osteoarthritis Osteoporosis Rheumatoid Arthritis Fibromyalgia
Lupus Hernia Herniated Disc History of Falls
TMJ Gout Headaches/Migraines Use Cane, FWW, w/c
Other: _____

Cardiovascular/Respiratory: Pacemaker Anemia High Cholesterol Asthma
Emphysema COPD High Blood Pressure Arrhythmia
Blood Clots Shortness of Breath Other: _____

Endocrine/Metabolic/Digestive: Diabetes Type I Liver Dysfunction Kidney Dysfunction
Diabetes Type II Thyroid Dysfunction Bladder Dysfunction
Irritable Bowel Syndrome Other: _____

Psychological: Depression Bipolar Disorder Obsessive Compulsive Disorder
Schizophrenia Anxiety Disorder Other: _____

Skin: Psoriasis Eczema Skin Allergies Rashes
Other: _____

Infectious Disease: HIV Tuberculosis Hepatitis Shingles
Influenza Other: _____

Cancer: Type: _____ Date of Diagnosis: _____
Treatment(s): _____

SIGNATURE _____ **DATE** _____