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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 ______________________ **Height** __________ **Weight** __________

Injury/Surgery Date/When you first noticed 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? ______________________________

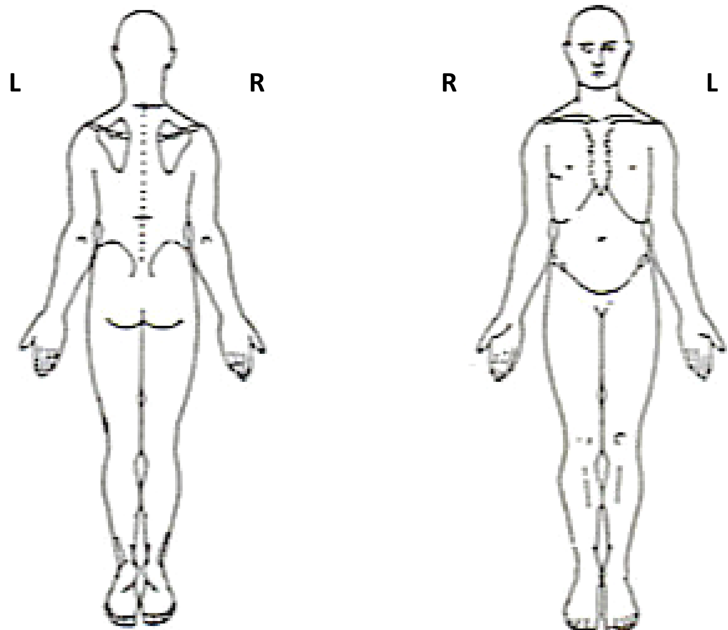
What was your average stress level PRIOR to your injury? Low Medium High

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): ______________________________

____

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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** ______________