

PATIENT HISTORY

PATIENT NAME _____ REFERRED BY _____
DATE OF FIRST OFFICE VISIT _____

1. Please list your bone, joint, muscle or nerve problems: _____

Date these problems began: _____

Have you ever had the same (or similar) problems before that time? (circle) YES NO
Cause of the current problem (circle): Work Injury Auto accident Illness
Sports Injury Other _____

Who was your employer at the time of the injury (if a work related injury)? _____

2. If pain is present what makes it worse? (Circle): Walking – Running – Turning - Standing
Kneeling - Bending - Carrying - Lifting - Driving - Lying down - Straining - Twisting - Jumping
Throwing - Pushing - Pulling - Coughing/sneezing - Climbing/descending stairs - Weather
changes - Sitting - Squatting - Stooping - Reaching - Grasping - Writing - Typing
Other _____

What makes it better? (Circle): Walking - Standing - Sitting - Heat - Lying down - Massage
Rest - Physical therapy - Exercises - Ice - Corset - Splint/brace - Firm mattress – Traction -
Special shoes/inserts – Chiropractor - Cortisone injection – Surgery - Alcohol - Medicines -
Decreased stress

Is the pain: (Circle) Worse in the morning - Worse in the midday - Worse in the evening –
Present all day - Associated with headaches - Awakens you at night- Associated with stiffness -
Associated with popping

Do you have any: (Circle) Numbness - Tingling – Weakness - Popping - Grinding - Swelling

3. Have you ever had a permanent disability award or rating for a work injury? _____
When? _____

4. PAST MEDICAL HISTORY
Special tests: (Circle) Myelogram - CT Scan - Electrical nerve test - Bone scan - MRI
Other injuries (list and give dates) _____

