PhysiYo

Patient Health and History

Name:_____ Date of Birth:_____

Pain Location:_____ Onset Date of pain/injury_____

Pain Scale: (circle one number in each line)

	None.....					Moderate.....				.....Extreme
At its worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10

Pain Description (check all that apply)

- ❑ Burning
- ❑ Sharp
- ❑ Dull
- ❑ Achy
- ❑ Throbbing
- ❑ Shooting
- ❑ Numbness/Tingling
- ❑ Constant
- ❑ Intermittent
- ❑ Worse in AM
- ❑ Worse in PM
- ❑ Worse at Night

Aggravating Factors (check all that apply)

- ❑ Sitting
- ❑ Standing
- ❑ Walking
- ❑ Stairs - up
- ❑ Stairs - down
- ❑ Sit to Stand
- ❑ Bending
- ❑ Voiding
- ❑ Lying Down
- ❑ Cough/Sneeze
- ❑ _____

Worse with:

- ❑ Bending
- ❑ Sitting
- ❑ Turning
- ❑ Rising
- ❑ Standing
- ❑ Walking
- ❑ Lying
- ❑ AM
- ❑ As day progresses
- ❑ PM
- ❑ When Still
- ❑ On the Move

Better with:

- ❑ Bending
- ❑ Sitting
- ❑ Turning
- ❑ Rising
- ❑ Standing
- ❑ Walking
- ❑ Lying
- ❑ AM
- ❑ As day progresses
- ❑ PM
- ❑ When Still
- ❑ On the Move

Previous history of similar symptoms:
(Circle one) YES NO

If YES, when was previous episode:
_____

Office Use Only: Entered into EMR_____ Date _____ Initials_____

Name of Occupation:

_____

Status: (please circle)

Full Time	Part Time	Light Duty
Transitional	Out of work	Retired
Not working	Homemaker	Student

Activity level:

- ❑ Sedentary
- ❑ Light
- ❑ Medium
- ❑ Heavy
- ❑ Very Heavy

Do you:

- Use tobacco YES NO
- Have a history of falls YES NO
  If yes, when _____

Medical history:

- ❑ No known significant history to affect treatment
- ❑ Alzheimer's
- ❑ Anxiety/Depression
- ❑ Cardiovascular Disease
- ❑ Cauda Equina Syndrome
- ❑ Cerebral Vascular Accident
- ❑ Current Infection
- ❑ Diabetes Mellitus Type 1
- ❑ Diabetes Mellitus Type 2
- ❑ Fibromyalgia
- ❑ Fracture Or Suspected Fracture
- ❑ High Blood Pressure
- ❑ History Of Cancer
- ❑ Huntington's
- ❑ Immunosuppression
- ❑ Lupus
- ❑ Muscular Dystrophy
- ❑ Obesity
- ❑ Osteoarthritis
- ❑ Parkinson's
- ❑ Rheumatoid Arthritis
- ❑ Traumatic Brain Injury
- ❑ Unexplained Weight Loss
- ❑ Currently Pregnant
- ❑ Other (describe below)

Please list Diagnostic Testing/Imaging:

_____

What are your goals:

- ❑ Decrease pain/inflammation
- ❑ Increase mobility
- ❑ Increase strength
- ❑ Other_____

Current Medications:

- ❑ Prescription_____
  _____
- ❑ Over The Counter_____
- ❑ Herbals _____
- ❑ Vitamin/Mineral/Dietary Supplements_____
- ❑ Not currently taking any medications