

MEDICAL HISTORY

Patient name: _____ Date of visit: _____

Name of Doctor who referred: _____

Date of injury or date pain started: _____

Please describe your symptoms: _____

Which activities, if any, increase your pain?

- Sitting
- Standing
- Lying down
- Bending
- Walking
- Coughing
- Sneezing
- Exercising
- Sex
- Other: _____

Which activities, if any, decrease your pain?

- Sitting
- Standing
- Lying down
- Walking
- Physical therapy
- Medication
- Other: _____

Which of the following activities does your pain keep you from doing?

- Sleeping
- Sex
- Sitting
- Standing
- Socializing
- Eating
- Working
- Exercising
- Walking
- Other: _____

Do you have any medical problems? Yes No If yes, describe: _____

Have you ever been in the hospital because of these problems? Yes No
If yes, describe: _____

Please list any medical problems that run in your family: (For example, diabetes, high blood pressure, etc.) _____

What is your vocation (work/job/employment)? _____

Are you still working? Yes No Does your pain interfere with your job?

- Most always
- Sometimes
- Very little
- Not at all

Do you smoke? Yes No If yes, for how long, how many packs? _____

Do you drink alcoholic beverages? Yes No If yes, how much, how often? _____

Please list any medications that you are currently taking including those you can buy without a prescription such as vitamins, herbs, and supplements: _____

Are you allergic to any medications? Yes No If yes, please list: _____

Have you ever had any surgeries? Yes No If yes, please describe and list doctor and year, if possible: _____

Have you been feeling sad, down in the dumps, or hopeless about your pain?

- Most always Sometimes Very Little Not at all

Do you have any hobbies that you enjoy? Yes No If yes, please describe: _____

Are you doing anything to relieve your pain? (therapeutic exercise, physical therapy, hot/cold etc.) Yes No If yes, please describe: _____

Have you noticed any change in your pain since trying these things? Yes No If yes, please describe: _____

What tests or treatments have you had?

Test or procedure:

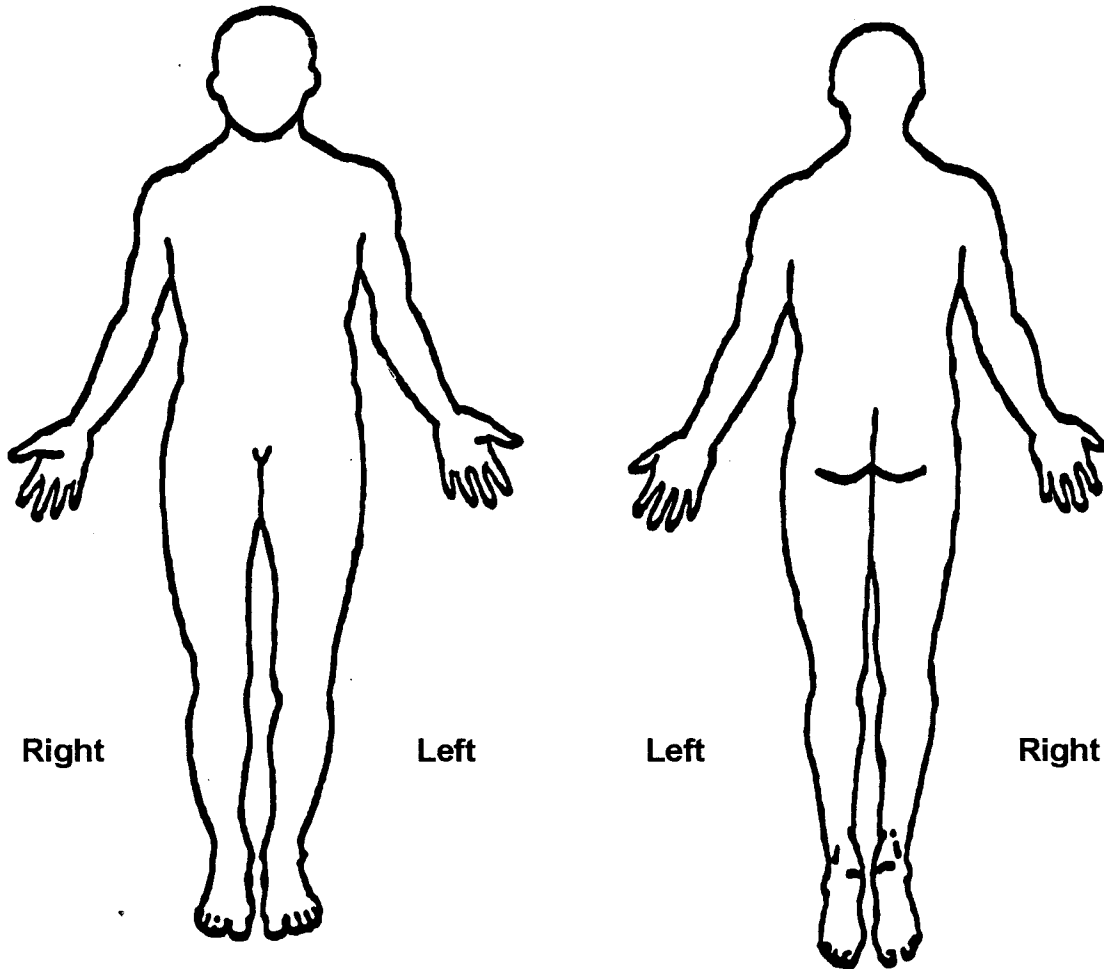
Where and/or by whom?

- Xray
- EMG
- MRI
- Muscle injection
- Physical therapy
- Anti-inflammatories
- Muscle relaxants
- Pain pills
- Surgery
- Epidural

Please mark on the body diagram below the areas where you feel sensations (defined below). Use the appropriate letters which correspond to the affected parts of your body. Please include all affected areas.

Definition of Sensations:

A=Aching B=Burning N=Numbness PN=Pins/Needles S=Stabbing



Please mark an X on the line below indicating how bad your pain is right now:

No Pain

Worst Pain
You've Ever Had

This concludes the medical history. Thank you.