Medical History

Date of current injury: _______________

Date of surgery: ______________ **Type:** ____

Are you off work due to your injury? Yes___ No___

If you are not off work, are you on restricted duty? Yes___ No___

What medications have you been prescribed for your current injury: ____________________________________

____

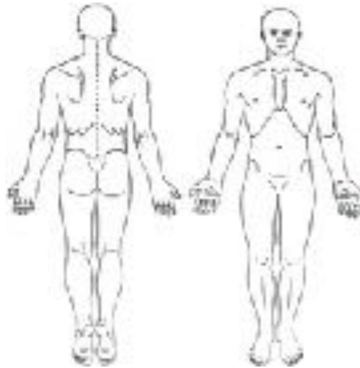
Average pain intensity:

Last 24 hours:	no pain	0 1 2 3 4 5 6 7 8 9 10	worst pain
Past week:	no pain	0 1 2 3 4 5 6 7 8 9 10	worst pain

How often do you experience your symptoms?

◯ Constantly (76%-100% of the time)	◯ Frequently (51%-75% of the time)
◯ Occasionally (26% - 50% of the time)	◯ Intermittently (0%-25% of the time)

Indicate below where you have pain or other symptoms



Nature of symptoms:
◯ Sharp ◯ Dull Ache ◯ Numb ◯ Shooting ◯ Burning ◯ Tingling

How is your condition changing:
◯ Getting Better ◯ Not Changing ◯ Getting Worse

What makes your symptoms worse?
____

What decreases your symptoms?
____

Have you had previous treatment for your injury? Yes___ No___

If yes, describe: ____

Have you had X-rays, MRI, or CT Scan for your area(s) of complaint? Yes___ No___

If yes, what were the results: ____

Select all that apply to you :

Diabetes	High Blood Pressure	Hearing Loss	Multiple Sclerosis
Heart Disease	Osteoporosis	Eye Disease	Hepatitis
Lung Disease	Epilepsy	Circulation Problems	Chemical Dependency
Osteoarthritis	Stroke	Blood Clots	Dizziness/Fainting
Rheumatoid arthritis	Depression	Ehlers-Danlos Syndrome	MRSA

Medical History

- **If you use tobacco, please understand that the chemicals in tobacco affect circulation and can have an adverse effect on the healing process**
- **Proper nutrition is important to both injury prevention and recovery from an injury. If you would like nutritional consultation, please ask your therapist for help in identifying a local dietician.**

Name:____ Date:___________________