PATIENT HISTORY QUESTIONNAIRE

GENERAL

NAME: _____ AGE: _____ TODAY'S DATE: _____

DOMINANT HAND: RIGHT:_____ LEFT:_____

What is the reason for you visit today? _____

How long has it been painful? _____

Was there an injury? _____ If yes, please describe: _____

_____

Where is your pain located? (front, back, top, medial, lateral, etc): _____

_____

Describe your pain (dull, sharp, constant, aching, etc.): _____

_____

What are some of your symptoms?

____Swelling/Fluid	____Weakness	____Popping/Clicking
____Bruising	____Night Pain	____Locking
____Instability	____Numbness/Tingling	____Stiffness
____Limited Range of Motion	____Referred/Traveling Pain	____Buckling/Giving Out

Pain Level: 1 2 3 4 5 6 7 8 9 10 (please circle)
Least Most

PREVIOUS TREATMENT:

1. Do you have any X-RAY's of your injured body part? _____
   If yes, when and where were they done & who was the ordering physician? _____
2. Do you have an MRI of your injured body part?_____
   If yes, when and at what facility did you have the MRI? _____
3. Are you taking medications specific to your pain? _____
   If yes, which medication(s)? _____
4. Have you had previous treatment by another Doctor, any Physical Therapist, Acupuncturist, or Chiropractic treatment for your injured body part? _____
   If yes, by whom & when? _____
5. Have you had any surgery on your injured body part? _____
   If yes, by whom & when? _____
6. Is a legal case involved with this injury? _____ Is this a work related injury? _____

IF YOU ANSWERED YES TO EITHER ONE OF THE QUESTIONS IN #6, PLEASE FILL OUT THE WORK RELATED INJURY FORM.

THANK YOU