Patient Health Information

Name _____ Date _____/_____/_____

Please describe your current complaint or limitation:

_____

_____

Please tells us when/how your problem began:

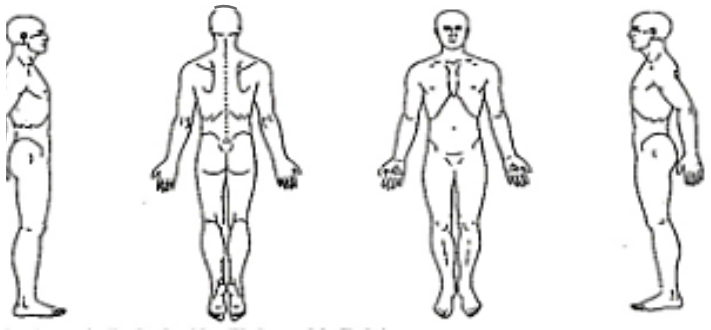
_____

Did you have surgery? **No** **Yes** Date___/___/____

Surgery Type: _____

Please circle the area of your pain on the body chart and check nature of below:

☐	Sharp pain	☐	Tingling
☐	Dull (pain) Ache	☐	Constant (76-100%)
☐	Throbbing	☐	Frequent (51-75%)
☐	Shooting	☐	Occasional (26-50%)
☐	Burning	☐	Intermittent (25- or less)



Indicate the intensity of your pain at worst: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable pain)

Indicate the intensity of your pain currently: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable pain)

Indicate the intensity of your pain at best: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable pain)

Since this condition began your symptoms have: **Decreased** **Not Changed** **Increased**

Your symptoms are worse in: **Morning** **Afternoon** **Night** **Increased during the day** **Same all day**

In the past have you been treated for this problem: **Yes** **No**

If yes, who did you see for this condition? **MD** **PT** **OT** **Chiropractor** **Other**_____

When and what treatment did you receive? _____

Occupation: _____ Has your work status changed because of this condition: **Yes** **No**

The information you provide concerning past & present conditions and diseases assists your therapist in more thoroughly understanding your state of health

Past	Present	
☐	☐	High Blood Pressure
☐	☐	Jaw Pain/TMJ
☐	☐	Heart Condition
☐	☐	Stroke
☐	☐	Asthma
☐	☐	Nervous System Disease
☐	☐	Cancer location:_____date____
☐	☐	Tumor
☐	☐	Hepatitis
☐	☐	Epilepsy/Seizure
☐	☐	Diabetes
☐	☐	Rheumatoid Arthritis
☐	☐	Arthritis
☐	☐	Pregnancy
☐	☐	Tobacco packs/day_____
☐	☐	Other_____

Hospitalizations/Surgical Procedures/Previous Injuries (if not elsewhere stated)_____

_____

_____

I have reviewed contradictions with the patient prior to initiating evaluation and treatment. The following contradictions were identified:

I have reviewed with the patient their rehabilitation potential prior to initiating treatment.

Patient/Guardian Signature **Date**

Therapist Signature **Date**