MEDICAL HISTORY AND PAIN QUESTIONNAIRE

Name: _____ DOB: _____ Date of Injury: _____ Today's date: _____

PRIMARY COMPLAINT: _____

TREATMENT: List any treatment PT, OT, Chiropractic, Osteopathic that you have received for this problem_____

DIAGNOSTICS/TESTS: List any special tests you have had for this condition:_____

MEDICATIONS you are currently taking:_____

GENERAL HEALTH: Check all that apply and give an explanation:

Past/Present	Past/Present	Past/Present	Past/Present
___ /___ Neck pain	___/___High blood Pressure	___/___ Diabetes	___/___ Allergies:_____
___/___ Mid back Pain	___/ ___Heart Attack	___/___ Epilepsy	___/___Smoking/Drug/Alcohol Use
___/___Shoulder pain	___/___Chest Pains/Angina	___/___Depression	___/___Hepatitis
___/___Low back pain	___/___Stroke	___/___HIV/AIDS	___/___Liver/Gallbladder Disorder
___/___Elbow pain	___/___Osteoporosis	___/___Cancer	___/___Multiple Sclerosis
___/___Wrist pain	___/___Jaw pain	___/___ Dizziness	___/___Rheumatoid Arthritis
___/___ Foot/Ankle pain	___/___Abdominal pain	___/___ Asthma	___/___Thyroid Disorder
___/___Knee pain	___/___Joint swelling	___/___Arthritis	___/___Concussion
___/___Hip pain	___/___Muscular Incoordination	___/___General Fatigue	___/___Headache

Explanations for checked health conditions: _____

RATE YOUR PAIN: "**0**" no pain at all and "**10**" worst possible (circle)

Pain today: 0 1 2 3 4 5 6 7 8 9 10

Worst pain in last 4 weeks: 0 1 2 3 4 5 6 7 8 9 10

Best pain in the last 4 weeks: 0 1 2 3 4 5 6 7 8 9 10

TYPE OF PAIN: (Circle all that apply)

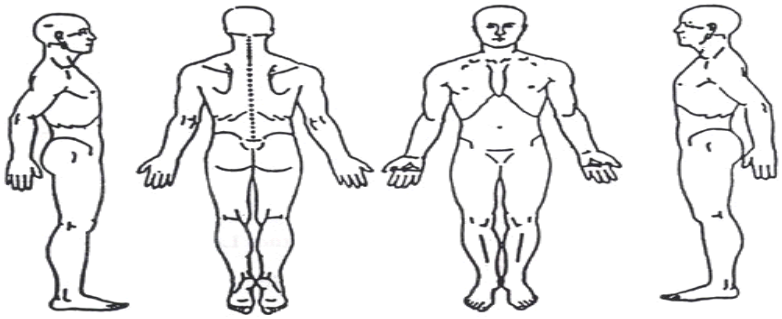
Throbbing Shooting Stabbing Sharp

Pinching Pulling Burning Tingling Numb

Tender Exhausting Fearful Nauseating

Agonizing Unbearable Radiating Aching

Mark on body using * where your pain is located:**



WELLNESS: Are you currently participating in a fitness program? Yes No

Are you interested in meeting with one of our Performance Coaches for a free initial visit? Yes No

Clinical Use Only: PT Dx:_____Recommendations/Goals:_____

UE Limits:_____ LE Limits:_____ Spinal Limits:_____