# GENERAL HISTORY

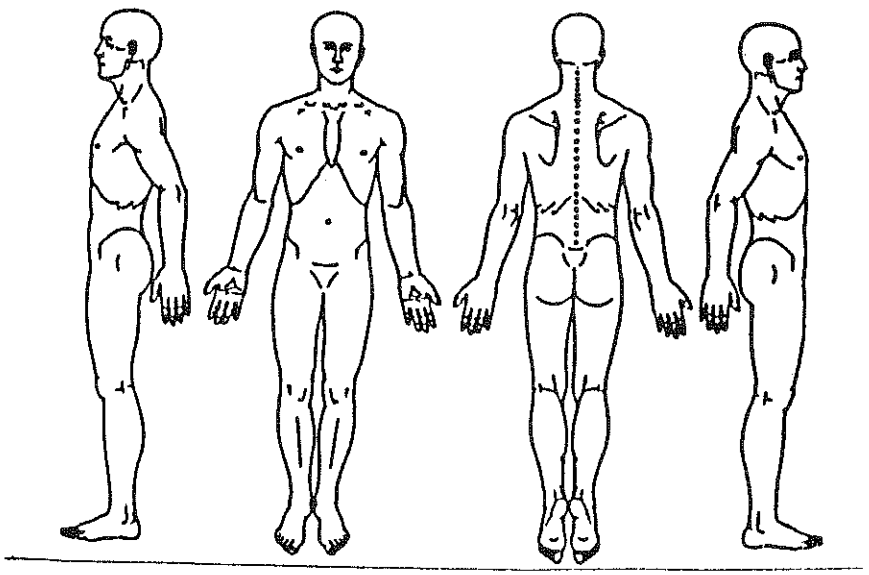
NAME _____ AGE _____ DATE _____

CHIEF COMPLAINT _____

DATE OF INJURY _____

REFERRING PHYSICIAN _____

BODY DIAGRAM: Please shade in the area of discomfort on the diagram below.



DISCOMFORT SEVERITY SCALE: 0 (NO PAIN) _____ 10 (WORST PAIN)

HISTORY: Please check "yes" or "no"

| | | |
|---|---|---|
| HEART DISEASE | ___ | ___ |
| RESPIRATORY PROBLEMS | ___ | ___ |
| ALLERGIES | ___ | ___ |
| DIABETES | ___ | ___ |
| CANCER | ___ | ___ |
| OSTEOPOROSIS | ___ | ___ |
| CORTISONE | ___ | ___ |

SPECIAL TESTS:

| | | |
|---|---|---|
| X-RAYS | ___ | ___ |
| LABORATORY | ___ | ___ |
| EMG | ___ | ___ |
| MYELOGRAM | ___ | ___ |
| ARTHROGRAM | ___ | ___ |
| STRESS TEST | ___ | ___ |
| OTHER TEST | ___ | ___ |

PLEASE ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

Any significant changes in weight lately? _____

Any changes in your appetite lately? _____

Any changes in bowel or bladder function lately? _____

Any feeling of being overtired lately? _____

Any shortness of breath? _____

Any general weakness, nausea, dizziness or feeling faint? _____

Specific weakness or lack of coordination or unsteadiness? _____

Any discomfort on exertion? _____

Any unusual discoloration of skin? _____

Any sensitivity to cold? _____

IS THERE ANYTHING ELSE PERTINENT TO YOUR PROBLEM THAT WE HAVE NOT DISCUSSED?

_____

_____

_____

PATIENT'S GOALS: (1)

(2)

(3)

THERAPIST COMMENTS AND NOTES:

HAVE YOU HAD ANY SIMILAR PROBLEMS IN THE PAST? IF SO, PLEASE EXPLAIN:

_____

_____

ARE YOU NOW ON ANY MEDICATION FOR THIS PROBLEM OR ANY OTHER PROBLEM?

_____

PROBLEMS POSSIBLY PERTINENT TO PRESENT CONDITION: Please check

| | "Yes" | "No" |
|---|---|---|
| INJURY | ___ | ___ |
| VIRUS JUST PRIOR | ___ | ___ |
| FLU JUST PRIOR | ___ | ___ |
| OVER TIRED JUST PRIOR | ___ | ___ |
| SURGERY | ___ | ___ |
| IMMOBILIZATION | ___ | ___ |
| MENTAL ILLNESS | ___ | ___ |
| SUSTAINED POSTURE | ___ | ___ |
| UNUSUAL ACTIVITY | ___ | ___ |
| HEAVY LIFTING | ___ | ___ |

What is your general level of activity? (PLEASE CIRCLE)

INACTIVE MILDLY ACTIVE
MODERATELY ACTIVE VERY ACTIVE

Has your level of activity changed? _____

Is your general level of stress or anxiety: MILD; MODERATE; SEVERE

Has your level of stress changed? _____

When did the pain begin? (DATE) _____

Was the pain SUDDEN ____, GRADUAL ____, OTHER ____?

Is your problem getting WORSE ____, BETTER ____, OR NOT CHANGING ____.

When your problem began was your discomfort in exactly the same location as you have it now? _____.

Is the pain constant or intermittent? _____.

Does your pain begin in the morning; as the day progresses; or at bedtime?

_____.

What aggravates your problem? _____.

What relieves your problem? _____.

Does your discomfort ever awake you at night? _____.

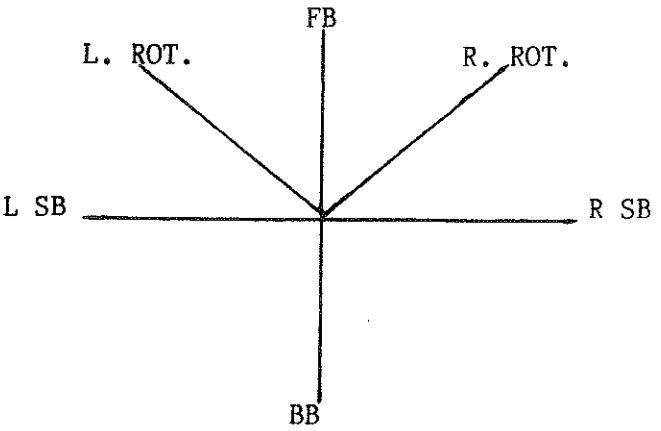
Is it hard for you to get back to sleep after you are awaken? If so, how long?

_____

OBJECTIVE EVALUATION FORM (THERAPIST USE ONLY)

OBSERVATION & INSPECTION:

POSTURE:




ACTIVE RANGE OF MOTION:

PALPATION: _____

_____

_____

NEUROLOGY: _____

SENSATION _____

REFLEXES _____

STRENGTH (MMT) _____

PROM: _____

_____

SPECIAL TEST: _____

_____

TREATMENT: _____

_____

GOALS: (1)

(2)

(3)

(4)

PLAN: _____

_____

_____

EXERCISES: