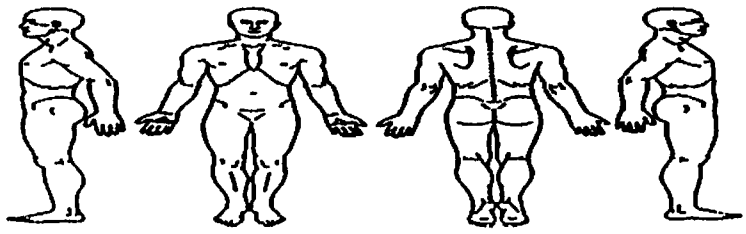
General History

Name: _____ **Date:** _____

Chief Complaint: _____

Referring Physician: _____ **PCP:** _____



Circle the area of your pain on the picture: Please rate your pain level between 1-10? _____

Onset Date of Injury: _____ **Is the problem getting worse, better or the same? (Circle one)**

What makes the pain worse? _____

What makes the pain better? _____

Does your discomfort wake you up at night? If yes, please explain how?

_____

_____

What diagnostic tests have you had? (i.e. Xray, MRI, CT Scan)

_____

_____

How is your stress level? Mild, Moderate or Severe (Circle one)

Have you experienced any abuse and /or trauma? If yes, please explain how?

_____

_____

What are your goals for physical therapy?

1. _____
2. _____
3. _____