



History Questionnaire

Patient Name: _____		Date: _____					
Date of Birth: ____/____/____ mm dd yy		Home Address: _____					
Telephone number: Home: _____ Other: _____		Postal Address (If different): _____					
Emergency Contact Name: _____							
Contact Phone Number: _____							
Date of Injury or symptoms: ____/____/____ mm dd yy		Description of injury or symptoms: _____					
Date of Surgery: ____/____/____ mm dd yy		Have you had this pain or problem before? YES NO	Is your pain on the surface or deep? Deep Surface				
Have you had any medical or physical therapy care for this injury? If yes, when and what							
	YES	NO	DATE		YES	NO	DATE
Chiropractor	<input type="checkbox"/>	<input type="checkbox"/>	_____	CT Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
Emergency Room	<input type="checkbox"/>	<input type="checkbox"/>	_____	EMG/NCV	<input type="checkbox"/>	<input type="checkbox"/>	_____
General Practitioner	<input type="checkbox"/>	<input type="checkbox"/>	_____	Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	_____
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Neurologist	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orthopedist	<input type="checkbox"/>	<input type="checkbox"/>	_____	Podiatrist	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other not listed: _____							

Medications: (include all medications)

Do you have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma			Vision Difficulty		
Bronchitis			Hearing Difficulty		
Emphysema			Dizziness or Fainting		
Shortness of Breath			Weakness		
Coronary Artery Disease			Weight Loss		
Angina			Energy Loss		
High Blood Pressure			Hernia		
Heart Attack/Heart Surgery			Epilepsy/Seizures		
Pacemaker			Thyroid trouble/Goiter		
Stroke/TIA			Blood Clot/Emboli		
Allergies			Headaches		
Metal Implants/Pins			Incontinence		
Joint Replacement			Bowel/Bladder Problem		
Diabetes			Neck Injury/Surgery		
Infectious Disease			Shoulder Injury/Surgery		
Cancer			Elbow or Hand Injury/Surgery		
Arthritis			Back Injury/ Surgery		
Osteoporosis			Knee Injury/Surgery		
Difficulty Sleeping			Leg/Ankle/Foot Injury/Surgery		
Neurological Problems			Gout		
Varicose Veins			Fibromyalgia		
Emotional Problems			Chronic Fatigue		
Vascular Problems			Anemia		
Lyme Disease			Shingles		
Are you pregnant?					

Please list any injury or illness not listed above:

Where is your pain? Neck Low Back Middle Back Shoulder Blade
 Shoulder Elbow Wrist Chest Hip
 Knee Ankle Foot Other _____

Does your pain move or stay in one place?

Patient Name:

My pain/problem is getting: <input type="checkbox"/> Same <input type="checkbox"/> Worse <input type="checkbox"/> Better
My pain bothers me: <input type="checkbox"/> Constantly <input type="checkbox"/> Most of the time <input type="checkbox"/> Occasionally <input type="checkbox"/> Once in awhile
What makes your pain worse?
What makes your pain better?
Do you have any numbness? Where?
Do you have tingling? Where?
On a scale of 1 to 10, What would you rate your worst pain to be? ____/10 <div style="display: flex; justify-content: space-around; margin-top: 10px;"> Mild discomfort Moderate Unbearable/Severe </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> 1 5 10 </div>
On a scale of 1 to 10, What would you rate your pain to be now? ____/10 <div style="display: flex; justify-content: space-around; margin-top: 10px;"> Mild discomfort Moderate Unbearable/Severe </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> 1 5 10 </div>
Patient Name:

On a scale of 1 to 10, What would you rate your best pain to be? _____/10

Mild discomfort

Moderate

Unbearable/Severe

1

5

10

Please mark the correct response (mild, moderate, or severe) for the words which best describe your pain. Leave the line blank if the word does not apply.

	MILD	MODERATE	SEVERE
1. Throbbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Shooting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Stabbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sharp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Cramping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Gnawing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Hot Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Aching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Heavy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Tender	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Splitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Tiring/Exhausting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Sickening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Cruel/Punishing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Throbbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Shooting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Stabbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Sharp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(For Office Use - Score: _____)

Patient Name:

Use the key below to mark the areas of the body where you are having problems:

Pain Key:

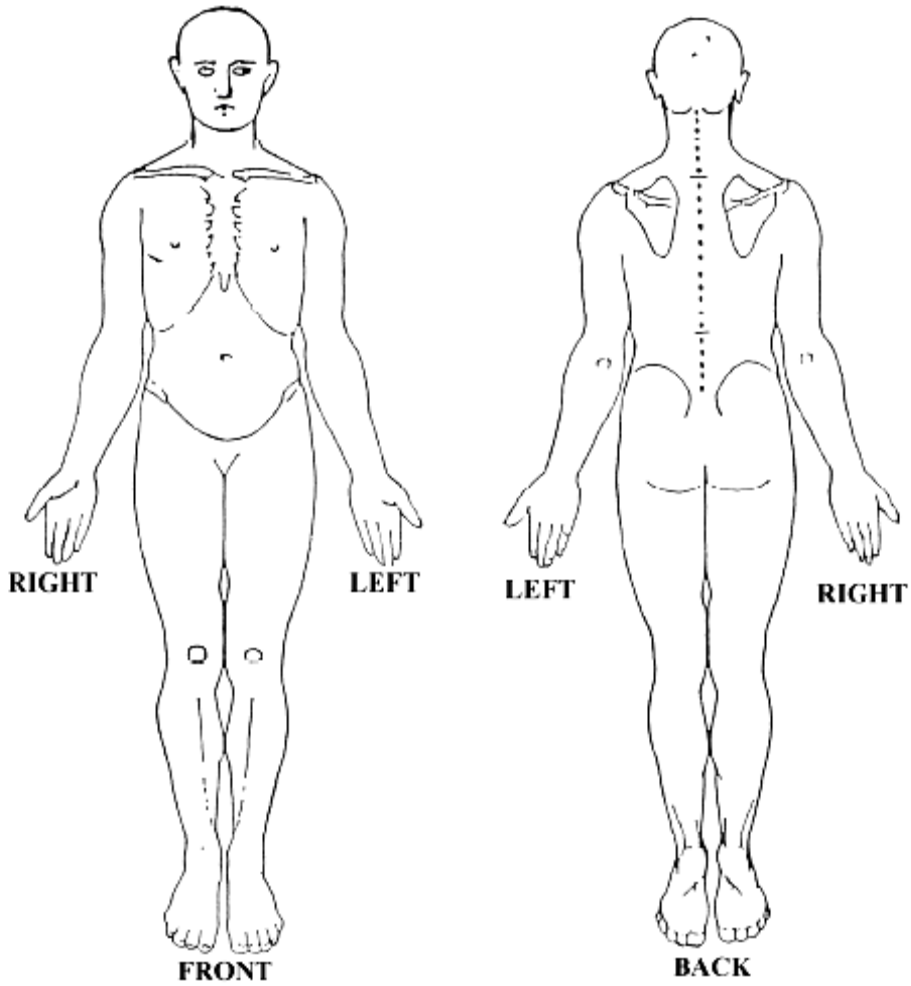
OOOO Pins and needles

XXXX Burning

//////// Stabbing

===== Dull Ache

PPPPP Other – describe _____



Patient Name

Signature

Date