

## HISTORY QUESTIONNAIRE

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Is this injury related to an Auto Accident?  Yes  No

Did this injury happen while at Work?  Yes  No

Do you have a current Workers Compensation Claim Open?  Yes  No

I am:  Male  Female

I am living:  Alone  Alone but with assistance for my needs  
 With an adult person(s)  With children in home, ages \_\_\_\_\_

I am currently:  Employed; my job is \_\_\_\_\_  
 I am on a sick leave  I am on disability  Applying for disability  
 I am unemployed  I am retired  I work inside the home

My physical activities include:

- Reading, watching TV
- Walking, gardening, housework, occasional physical exercise
- Regular physical exercise at least twice per week

I began having pain/symptoms on or about: \_\_\_\_/\_\_\_\_/\_\_\_\_

I have had this condition:  Never until now  Once  Many times before

My pain/symptoms were caused by (check all that apply):

- Accident or Injury Explain: \_\_\_\_\_
- Surgery Explain: \_\_\_\_\_  
Date of surgery: \_\_\_\_/\_\_\_\_/\_\_\_\_
- Suddenly without any reason
- Gradually worsening over time
- Due to a change or increase in activity
- Don't know

My symptoms are currently:  Getting Better  Getting Worse  Staying about the same

What makes your symptoms worse (check all that apply):

- Lying down  Standing  Walking  Sitting  Stress
- Other: \_\_\_\_\_

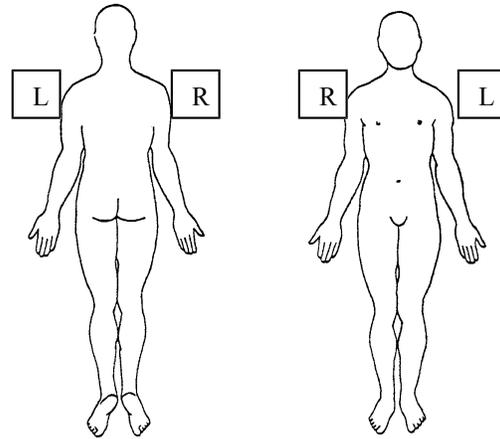
What makes your symptoms better: \_\_\_\_\_

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## Body Chart:

On the chart to the right, please mark the areas where you feel symptoms, by using the following symbols:

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



I would rate my pain **CURRENTLY** as:

0 1 2 3 4 5 6 7 8 9 10  
(None) (Annoying) (Uncomfortable) (Horrible) (Excruciating)

The **LEAST** pain I have had **IN THE LAST WEEK** is:

0 1 2 3 4 5 6 7 8 9 10  
(None) (Annoying) (Uncomfortable) (Horrible) (Excruciating)

The **WORST** pain I have had **IN THE LAST WEEK** is:

0 1 2 3 4 5 6 7 8 9 10  
(None) (Annoying) (Uncomfortable) (Horrible) (Excruciating)

I am currently taking the following medications (check all that apply):

- Pain pills
- Anti-inflammatory medication
- Muscle relaxants
- Antidepressants
- Blood thinners
- Please list medication(s) or attach a list:

\_\_\_\_\_

Allergies: \_\_\_\_\_

I have had these tests done recently:

- None
- X-ray
- MRI
- CAT Scan
- Ultrasound
- Other: \_\_\_\_\_

Please describe any results: \_\_\_\_\_

I have had these treatments for any reason:

- Physical Therapy
- Occupational Therapy
- Chiropractic Care
- Other: \_\_\_\_\_
- None

Past Surgeries: \_\_\_\_\_

I have **RECENTLY** had the following symptoms (check all that apply):

- stiffness
- shortness of breath
- muscle weakness
- swelling
- fever / chills / sweats
- spasms
- radiating pain down arms
- dizziness / lightheadedness
- difficulty swallowing
- radiating pain down legs
- unexplained weight loss / gain
- fainting
- lack of strength / awkwardness with my hands
- heartburn / indigestion
- fatigue
- lack of strength / awkwardness with my legs
- recurring headaches
- cough
- difficulty maintaining balance while walking
- difficulty sleeping
- falls

- increased pain at night
- numbness / tingling
- nausea / vomiting
- bowel or bladder changes
- confusion
- changes in skin

**I have (or have had) (check all that apply):**

- cancer
- arthritis
- anemia
- heart disease / condition
- chest pain / angina
- asthma
- circulation problems
- bladder / kidney problems
- other \_\_\_\_\_
- depression / anxiety
- rheumatoid arthritis
- seizures
- lung problems
- plastic or metal implants
- liver problems
- ulcers
- GYN problems \_\_\_\_\_
- thyroid problems
- osteoporosis
- blood clots
- drug or alcohol abuse
- stroke
- pacemaker
- fibromyalgia

- high blood pressure (If yes, is this well controlled)  yes  no  unsure
- diabetes (If yes, is this well controlled)  yes  no  unsure
- current* smoker  yes  no *past* smoker  yes  no *currently* pregnant  yes  no

**During the past month, have you often been bothered by little interest or pleasure in doing things that you enjoy?**  Yes  No

**During the past month have you often been feeling down, depressed or hopeless?**  Yes  No

**If yes, is this something with which you would like help?**  Yes, but not today  Yes  No

**Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?**  Yes  No

**What activities are you having difficulty doing because of your pain or dysfunction?** \_\_\_\_\_

**What is your personal goal for therapy?** \_\_\_\_\_

**Is there any other information or concerns you would like to share with your therapist?** \_\_\_\_\_

Patient Name (Printed): \_\_\_\_\_

Date: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_

**To our patients:** Although many of these questions may not seem relevant to your visit today, we ask that you communicate with us regarding symptoms or history you have, as this information can be of great assistance in determining whether therapy is indicated, and to what degree it may be of help. And even if your provider is aware of a symptom or illness, please let us know about it, and also if there has been any worsening of late. An important aspect of treating musculoskeletal injuries is screening for other conditions and factors that may play a role in your symptoms; this helps us to provide effective interventions, and to be advocates for your overall wellbeing and health.

**For therapist use:**

Self reported or functional index score: \_\_\_\_\_/\_\_\_\_\_  
Oswestry Cervical Index DASH LEFS UEFI FABQ FAAM Other: \_\_\_\_\_

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Therapist signature

Date