Patient Present Illness/Injury Questionnaire

__New Patient __Reactivate __ New Episode __Aggravation __Other

Patient Name_____ Date_____

CHIEF COMPLAINT

Read All Instructions! Complete Front and Back of Page!

•Mark the figures below with the symbols describing your pain sensation. Use the appropriate symbols. If there is more than one area of complaint, number them according to severity. •Please rate the pain on a scale of 0 to 10 next to each area, with 0 being NO pain and 10 being INTOLERABLE pain.

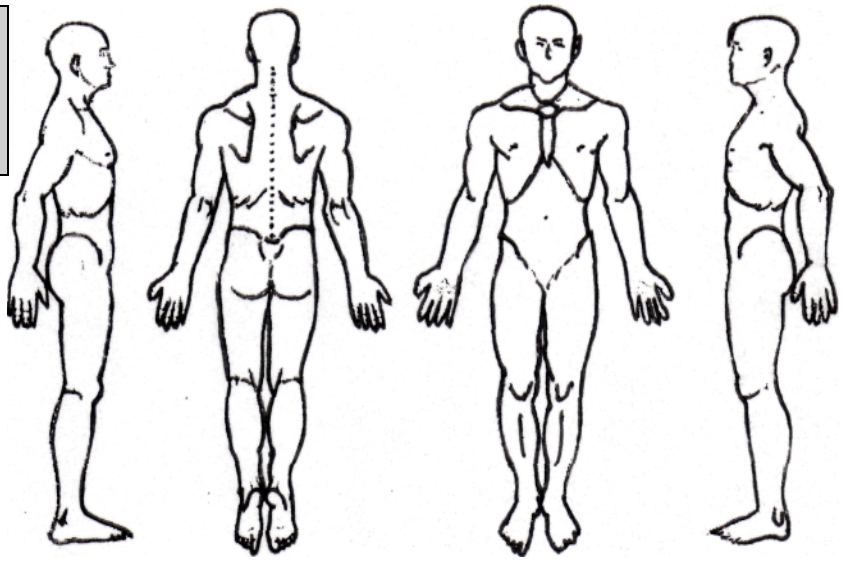
•Describe Your Symptoms: _____

_____

_____

_____

+++ Burning
(((Aching Pain
>>> Pins & Needles
000 Numbness
:::: Sharp Pain
XXX Dull/Crampy



•When Did Your Symptoms Start? _____

_____

•How Did Your Symptoms Begin? _____

_____

•How Often Do You Experience Your Symptoms?
__ Constantly (76-100% of the day)
__ Frequently (51-75% of the day)
__ Occasionally (26-50% of the day)
__ Intermittently (0-25% of the day)

How Are Your Symptoms Changing?
__ Getting Better __ Not Changing __ Getting Worse

•What Makes Your Symptoms Worse?_____

•What Makes Your Symptoms Better?_____

•When are your Symptoms:
Better? __AM __Mid-day __PM
Worse? __AM __Mid-day __PM

•Who have you seen for your <u>current</u> symptoms?
__No One __ Physical Therapist __ Medical Doctor __ Chiropractor __ Other_____

a. What treatment did you receive? _____
b. What was your perceived outcome?_____
c. What tests were used for your symptoms and when?
__ X-Rays Date:_____ __MRI Date:_____ __ CT Scan Date:_____ __Other_____ Date:_____

•Have you had the same/similar symptoms in the past? __Yes __No **How many times?** __ 0-3 __ 4+

If Yes, who did you receive treatment from and what?_____

•During the past <u>4 Weeks</u>, how much has the pain interfered with your work (including housework, job, etc)?
__Not at all __ Little bit __ Moderately __Quite a bit __ Extremely

•During the past <u>4 Weeks</u>, how much has the pain interfered with your Social Life?
__Not at all __ Little bit __ Moderately __Quite a bit __ Extremely

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ACTIVITIES OF DAILY LIVING

Indicate Your Ability to Perform the Following Activities. Please Use These Codes.

U-Unable **L**-Limited **P**-Painful **D**-Difficult **N**-Normal **H**-Haven't Tried

1.___Lying on Back
2.___Lying on Side
3.___Lying Flat on Stomach
4.___Turning Over in Bed
5.___Getting In/Out of Car
6.___Reaching
7.___Gripping
8.___Climbing
9.___Pulling
10.___Dressing Self
11.___Sexual Activity
12.___Sleeping
13.___Pushing
14.___Kneeling
15.___Stooping
16.___Sitting (work,home)
17.___Bending Forward
18.___Walking Short Distances
19.___Bending to Brush Teeth
20.___Standing 1+ hours
21.___Balancing
22.___Cough/Sneeze/Grunt
How?_____
Where?_____

23.___Other_____ 24.___Other_____ 25.___Other_____

FILL OUT NEXT SECTIONS AS THEY APPLY TO YOU

HEADACHE

Yes No

Do You Experience:

___ ___ Nausea, Vomiting, or Visual Disturbances?
___ ___ Radiation (travel) of Pain from Neck?
___ ___ Pain/Clicking in Jaw?
___ ___ Abnormal Blood Pressure?
___ ___ Family History of Headaches?

Frequency of Headaches:_____
Date of Last Eye Exam: /

LUMBOSACRAL SPINE (Lowback)

Yes No

___ ___ Feeling of Ripping or Tearing?
Where?_____
___ ___ Does the Pain Radiate (travel) to the Abdomen?
___ ___ Does the Pain Radiate (travel) into the Leg?
___ ___ Impairment of Bowel or Bladder Function?
Explain:_____

CERVICAL SPINE (Neck)

Yes No

___ ___ Neck Injury that Affects Hearing, Vision, Balance or Causes Ringing in Ears?
___ ___ Do You Hear Grating Sounds?
___ ___ Is Your Swallowing Affected?

Yes No

___ ___ Difficulty Turning Head? __Right __Left
___ ___ Pain/Pressure Behind Eyes?
___ ___ Feeling of Ripping/Tearing
Where?_____

What Are Your Goals? Office Use Only

•Condition #1:_____

Goal #1:_____

_____

Goal #2:_____

_____

•Condition #2:_____

Goal #1:_____

_____

Goal #2:_____

_____

Physician Signature:_____ Date: ____/____/_____