INITIAL CONDITION

Patient Name: _____ Date: ____/____/____

Primary Care Physician & Clinic: _____ Phone: ( )_____

Doctors treating you for this condition: _____ Phone: ( )_____

Therapists treating you for this condition: _____ Phone: ( )_____

Date of initial onset for this condition: _____ If reoccurrence, date of current aggravation: _____

Describe how the injury occurred: _____

_____

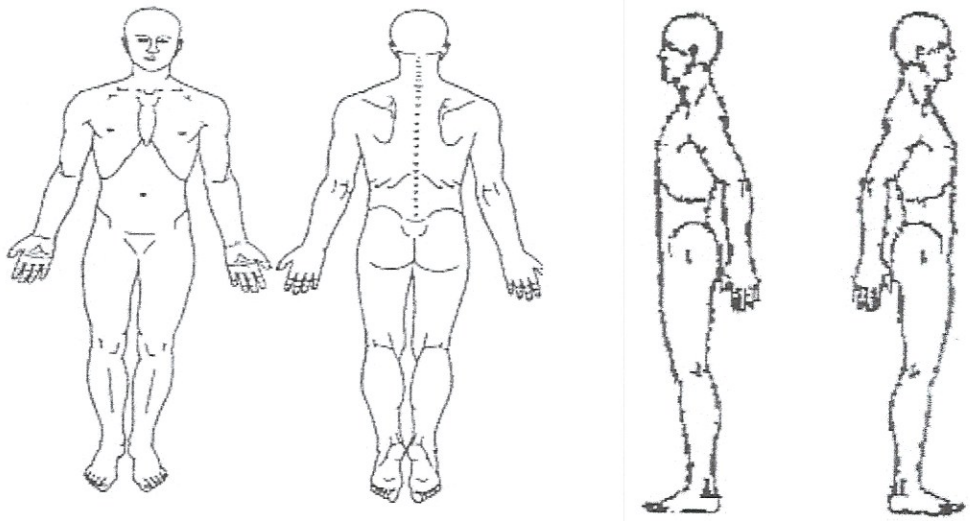
When did your problem begin? ☐Immediately after a specific incident ☐Multiple incidents ☐Gradually developed

☐ No specific incident - Please list the "incident/s": _____

Pain Diagram: Use symbols below to mark the figures.

Description:
XXX = Aching
/ / / = Numbness
>>> = Stabbing
= Burning
000 = Pins/Needles
TTT = Throbbing

Frequency (overall):
☐Constant (76-100%)
☐Frequent (51-75%)
☐Occasional (26-50%)
☐Intermittent (25% or less)



Rate Intensity as Follows (This Section):

0 None
1 Maybe
2 Mild, forgotten w/activity
4 Moderate, bothers during work/activities
6 Limiting, prevents full activity
8 Intense, preoccupied, seeks relief instead of activity
10 Severe—on bed rest, stops all activity

Complaint (i.e. Neck Pain, Low Back Pain, etc) Place "X" for average pain, "O" worst pain, "☐" pain now		Is it getting		
		Better	Worse	No Change
1._____	0....1.....2.....3.....4.....5.....6.....7.....8.....9.....10	☐	☐	☐
2._____	0....1.....2.....3.....4.....5.....6.....7.....8.....9.....10	☐	☐	☐
3._____	0....1.....2.....3.....4.....5.....6.....7.....8.....9.....10	☐	☐	☐
4._____	0....1.....2.....3.....4.....5.....6.....7.....8.....9.....10	☐	☐	☐

Your general stress level: ☐No stress ☐Minimal stress ☐Moderate stress ☐Greatly stressed

Physical activity at work: ☐Sitting more than 50% of day ☐Light manual labor ☐Manual labor ☐Heavy manual labor

General physical activity: ☐No regular exercise program ☐Light exercise program ☐Strenuous exercise program

Please describe any other physical/emotional/hormonal medical concerns that you are considering seeking care for, currently receiving care for, or in the past have sought care for:

_____

Patient signature _____ Date _____ → (please see other side)

Patient Name: _____

For ALL new patients and patients who have had a new injury please answering the following.
If you have ever been treated for a listed condition in the past, please check it in the Past column.
If you are currently under the care of a medical professional for a listed condition, check it in the Present column.

Past	Present	
☐	☐	Neck Pain (723.1)
☐	☐	Shoulder Pain (719.41)
☐	☐	Pain in Upper Arm or Elbow (719.42)
☐	☐	Hand Pain (719.44)
☐	☐	Wrist Pain (719.43)
☐	☐	Upper Back Pain (724.1)
☐	☐	Low Back Pain (724.2)
☐	☐	Pain in Upper Leg or Hip (719.45)
☐	☐	Pain in Lower Leg or Knee (729.5)
☐	☐	Pain in Ankle or Foot (719.47)
☐	☐	Jaw Pain (526.9)
☐	☐	Swelling/Stiffness of Joint(s)
☐	☐	Dizziness (780.4)
☐	☐	Headache (784.0)
☐	☐	Muscular Incoordination (781.3)
☐	☐	Rapid Heart Beat (785.0)
☐	☐	Chest Pains (786.50)
☐	☐	General Fatigue
☐	☐	Breast Soreness/Lumps (611.72)
☐	☐	Abdominal Pain (789.0)
☐	☐	Constipation/Irregular Bowel Habits (564.0)
☐	☐	Heartburn/Indigestion (787.1)
☐	☐	Dermatitis/Eczema/Rash (692.9)
☐	☐	Depression (311)

Past	Present	
☐	☐	Aortic Aneurysm (441.5)
☐	☐	High Blood Pressure (401.9)
☐	☐	Heart Attack (410.9)
☐	☐	Stroke (436)
☐	☐	Asthma (493.9)
☐	☐	Cancer (199.1)
☐	☐	Tumor (229.9)
☐	☐	Prostate Problems (601.9)
☐	☐	Blood Disorder (790.6)
☐	☐	Emphysema (chronic lung disorders) (492.8)
☐	☐	Arthritis (716.9)
☐	☐	Rheumatoid Arthritis (714.0)
☐	☐	Diabetes (250.0)
☐	☐	Epilepsy (349.5)
☐	☐	Ulcer (556.9)
☐	☐	Hepatitis (573.3)
☐	☐	Irritable Colon (564.1)
☐	☐	HIV/AIDS (042)
☐	☐	Systemic Lupus
☐	☐	Other _____

If you or a family member has had any of the following, please mark the appropriate box:

☐ Cancer
☐ Rheumatoid Arthritis
☐ Diabetes
☐ Heart Problems
☐ Lung Problems
☐ High Blood Pressure
☐ Lupus
☐ Epilepsy
☐ Chronic Back Problems
☐ Chronic Headaches
☐ Other Conditions _____

Please check any of the following that apply to you:

Past	Present	
☐	☐	Pregnancy (V22.2)
☐	☐	Birth Control Pills
☐	☐	Hormonal/Estrogen Replacement
☐	☐	Medications (please list) _____
☐	☐	Vitamins/Herbs_____
☐	☐	Hospitalization/Surgical Procedures (please list) _____

Past	Present	
☐	☐	Tobacco (305.1)
☐	☐	Alcohol (305.0)
☐	☐	Drug or Alcohol Dependence (303.9)
☐	☐	Coffee/Tea/Caffeinated Soft Drinks: _____ _____

Present Weight: _____pounds **Height:** _____feet _____inches

Therapist's additional comments/general health concerns: _____

_____

_____

Patient's signature: _____ **Date** _____/_____/_____