History of Current Condition

Name : _____ Birthdate: _____ Age: _____Sex: _____

Referring Physician: _____ PCP: _____

Occupation: _____

Where is your problem *located*? _____

When did it happen? (Date of Injury) _____

How did it happen? _____

_____

How *severe* is your problem? Mild Mod Severe Other: _____

_____

Where is your pain? Front Back Side Other: _____

What is your pain quality? Dull Sharp Aching Stabbing Throbbing Shooting
Sore Other: _____

When does it occur? Constant Daily In the AM At sleep
End of day During activity After activity Occasional

What makes it better? Ice Heat Rest Elevation Other:

What makes it worse? _____

_____

Associated Symptoms? Weak Numbness Tingling Popping
Catching Grinding Locking Buckling
Pain with overhead activity Other: _____

What treatment have you tried? Physical Therapy Injections Medication
Surgery Bracing
Other: _____

Have you ever injured this before? Yes No

If Yes Explain: _____

Continued on reverse side

Clinical Use Only

Patient ID # _____

Please (circle) any *current* problems or concerns

General:

Fevers

Chills

Weight loss

Eyes:

Discharge from eye

Changes in vision

Head and Neck:

Headache

Lightheadedness

Sinus pain

Sore throat

Cardiovascular:

Chest pain

Rapid heart rate

Respiratory:

Shortness of breath

Cough

Gastrointestinal:

Nausea or vomiting

Diarrhea or constipation

Bloody stools

Genitourinary:

Urinary urgency or frequency

Burning

Skin:

Rash

Itching

Neurologic:

Muscle weakness

Loss of coordination or balance

Endocrine:

Frequent urination

Increased thirst

Cold intolerance

Psychiatric:

Anxiety

Depression

Heme/Lymphatic:

Easy bleeding or bruising

Lymph node tenderness

Allergy/Immunologic:

Allergic dermatitis

Seasonal allergies

No current problems or concerns