Medical History Intake

Name_____

Age_____

DOB_____

Occupation/School_____

Activities/Sports_____

Diagnosis_____

Onset of Symptoms

Gradual / Acute

Onset Date_____ **Injury / Accident Date**_____

Surgery Date_____ **First MD Visit**_____

Mechanism of Injury_____

Chief Complaints_____

Side of body affected Right Left Both

Dominant Hand / Arm Right Left

Pain Location Please shade areas on attached body chart on next page

Pain Intensity None - 1 2 3
4 5 6 7 8 9
10 - Severe

Pain Quality Dull Sharp Aching Stinging
Burning Throbbing Tingling
Locking Popping Grinding
Other_____

Pain Increased with: Lifting Forward Bending Sitting Standing
Walking Twisting Sleeping
Running Jumping Driving Laughing
Coughing Sneezing AM/PM Typing
Chewing Neck/Torso Rotation Other_____

Pain Decreased with

Pain Duration / Patterns : constant intermittent radiating localized other

Pain effects on daily life, recreation, etc.

Surgical History

PT History

Medical History:

Medications:

Diagnostic Tests

Patient Goals

Please shade area(s) of pain and/or symptoms.