

## History of Present Illness

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_      \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
D.O.B                      Date

(for office use only)

1. **What** is the **complaint** that brings you here? \_\_\_\_\_  
\_\_\_\_\_

2. **When** did this complaint begin, or recently become worse? \_\_\_\_\_  
Approx. date: \_\_\_\_\_

3. **What caused** this complaint? \_\_\_\_\_  
\_\_\_\_\_

Work related accident? \_\_Yes \_\_No    Auto accident? \_\_Yes \_\_No

**Your occupation:** \_\_\_\_\_

Work intensity: \_\_sedentary \_\_light \_\_medium \_\_heavy

Work Status: \_\_full time \_\_part time \_\_not working \_\_retired

\_\_medical restrictions \_\_medical leave /**Last date worked:** \_\_\_\_\_

4. Does this complaint affect your **activity**: \_\_Yes \_\_No  
If Yes, what activities?

walking                       no limit     limited \_\_\_\_\_ distance/ time

sitting                         no limit     limited \_\_\_\_\_ time

standing                       no limit     limited \_\_\_\_\_ time/ minutes

lifting                          no limit     limited \_\_\_\_\_ pounds

dressing/ bathing           no limit     limited \_\_\_\_\_

stair climbing               no limit     limited \_\_\_\_\_ steps

driving                         no limit     limited \_\_\_\_\_ time

recreational activities     no limit     limited \_\_\_\_\_ time

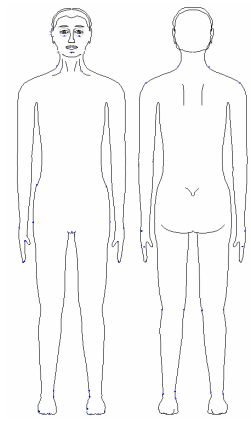
what activities? \_\_\_\_\_

5. Estimate your current **level of activity**: \_\_\_\_\_ % of usual

6. What makes this complaint **worse**? \_\_\_\_\_  
\_\_\_\_\_

7. What makes this complaint **better**? \_\_\_\_\_  
\_\_\_\_\_

8. What are your **symptoms**?  loss of motion (stiffness)  numbness  
 swelling  loss of balance or coordination  
 pain (**indicate location on body diagram to the right**)  
 difficulty walking  weakness  tingling  
 other (please specify) \_\_\_\_\_



9. **Quality** of your pain:  sharp  dull  burning  ache  throbbing  
 Other: \_\_\_\_\_

10. What is the **intensity** of your pain at **best** and at **worst**? (**please circle two #'s**)  
 0 1 2 3 4 5 6 7 8 9 10  
 none v. mild mild moderate severe v. severe  
 (worst imaginable)

11. The symptoms are  Constant  Intermittent

12. What **time of day** are your symptoms... worst \_\_\_\_\_ best \_\_\_\_\_?

12. Do you have increased pain with coughing or sneezing?  Yes  No

13. Is your sleep interrupted by this problem?  Yes  No

14. Sleep position: SIDE:  right  left  STOMACH  BACK  ALL

15. Do you live with others?  Yes  No  
 Are there stairs in your home?  Yes  No Rails?  Yes  No

17. Ht \_\_\_\_\_ Wt \_\_\_\_\_ Significant weight gain/ loss?  Yes  No

18. What **tests** have you had for this complaint?

X Ray  CAT Scan  MRI  Bone scan

Bone Density  Other \_\_\_\_\_

19. What **treatment** have you had for this complaint?

Physical Therapy  Occupational Therapy  
 Medication  Injection  Surgery  Chiropractic  
 Other \_\_\_\_\_

20. Your **goals** for therapy are: \_\_\_\_\_

**Thank you for taking the time to complete this form.**

*By signing below, I verify that the information I have provided is complete and accurate.*

\_\_\_\_\_  
 Patient Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Therapist Signature

\_\_\_\_\_  
 Date