Medical History

1. Have you had surgery for this injury and if so please describe the procedure including the date and your surgeons name:

_____

_____

2. Have you had physical therapy or other treatment for this injury in the past?
If so, please describe your previous treatment:

_____

_____

3. When did your symptoms or injury first occur? Did your symptoms arise gradually or suddenly? Please describe

_____

_____

4. Are your injuries work related or due to a motor vehicle accident? Is so, please describe and what is the date injury/accident?

_____

5. Please describe your current symptoms:

_____

_____

_____

6. Rate your current level of pain on a scale of *0 - 10* (*0* = no pain, *10* = excruciating pain)

_____

7. Is your pain constant or intermittent? (circle one) Yes / No

8. Does your pain wake you up at night? Yes / No

9. What activities make your pain worse?

_____

_____

10. Does your pain follow a pattern where it is worse in the am or pm? Yes / No

11. Do you have radiating pain that could be describes as burning or electrical? Yes / No

12. Do you have numbness or tingling in your one or more of your extremities (leg or arm)? Yes / No

13. Please describe your current functional limitations (ie: walking, stairs, getting out of bed, recreational activities, etc):

_____

_____

_____

14. Are you taking pain or anti-inflammatory medication, if so please list below:

_____

_____

_____

_____

15. Please list your normal recreational or sport related activities when healthy:

_____

_____