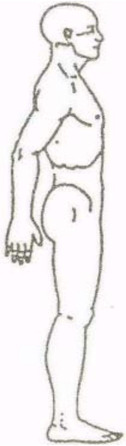
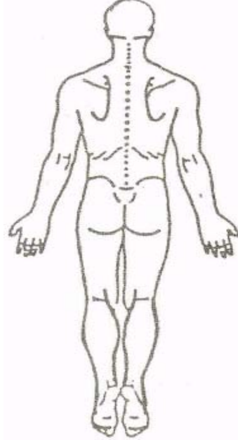
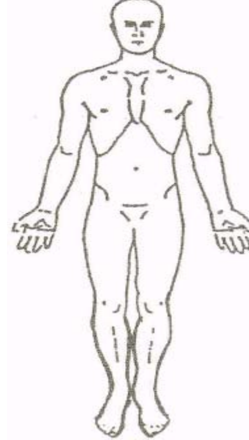
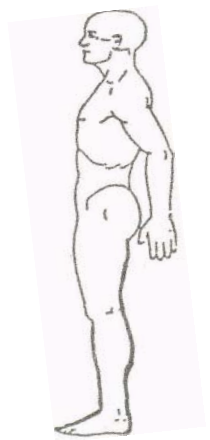
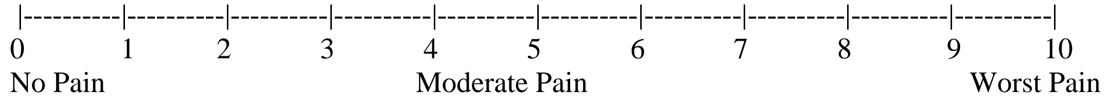
PATIENT MEDICAL HISTORY FORM (Continued)

Are you taking any medications presently? NO_____ YES_____ If so, please list:________________________________

13. Describe the nature of your problem and indicate on diagram where: ____

Please indicate your CURRENT pain level on the chart below:



14. What if any treatments have you had for this current problem? ____

Did they help? Yes____ No____

15. What in particular makes your pain worse? ____

16. What, if anything, eases the pain? ____
17. Can you get comfortable at night? Yes___ No___
18. How do you feel upon rising? Stiff___ Sore___ Fine___
19. Once you start moving about, does it worsen____ or ease____?
20. What is it like at the end of the day? Worse___ Easier____
21. Do you have any pins and needles, etc? Yes___ No___ (if yes, please indicate location on diagram above)
22. At this time, do you consider you are getting better___, worse___ or stable___?

Please rate your ability to perform the following activities:
1-Not Limited 2-Can do with some difficulty 3-Can do with significant difficulty 4-Can't do at all

Sleeping___ Dressing___ Sitting___ Standing___ Walking___ Housework___
Driving___ Stairs___ Sporting Activities___ Sexual Activity___ Yardwork___

WHAT GOALS DO YOU WANT TO ACHIEVE WITH THERAPY?_____________________________________

Patient Signature:______________________________________ Date:____________________________________