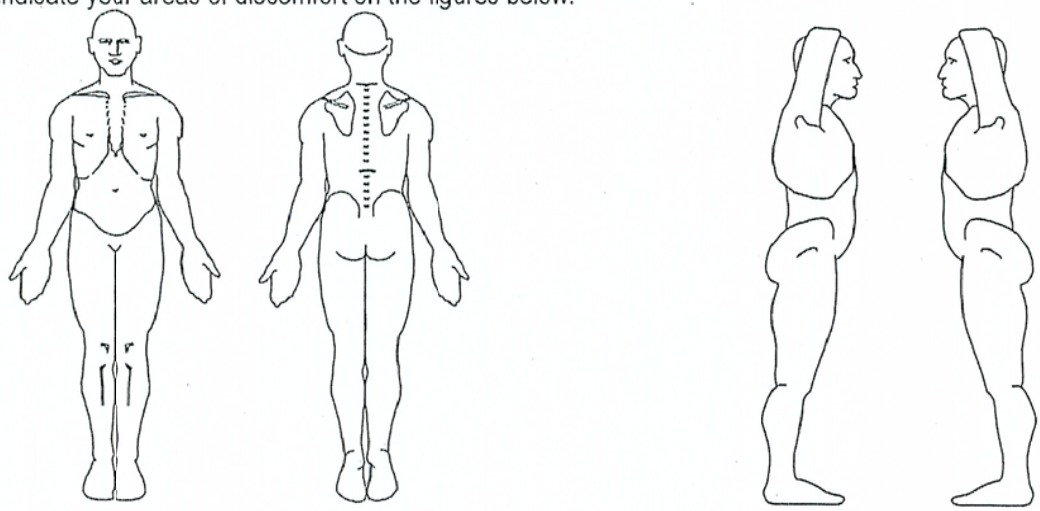
MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date of Birth:_____ Occupation:_____Date: _____

What problem are you here for today? _____ When did the problem start? _____

Describe how your problem or injury occurred: _____

Please indicate your areas of discomfort on the figures below.



Please rate your pain on a scale of 0 to 10, with 0 indicating no pain and 10 indicating unbearable pain. Circle the number for the amount of pain you have **at rest** and **with activity**.

Pain at rest:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Unbearable Pain
Pain with activity:	No Pain	0	1	2	3	4	5	6	7	8	9	10	Unbearable Pain

What is the frequency of your pain?

☐ Constant ☐ 4 or more times/day ☐ 1 to 3 times/day ☐ 4 or more times/week ☐ 1 to 3 times/week ☐ No pain

Does your pain awaken you at night? ☐ Yes ☐ No If yes, how many times per night? _____

Do you have days or periods of time when you are completely pain-free? ☐ Yes ☐ No

What eases your symptoms? ☐ Heat ☐ Ice ☐ Rest ☐ Medication ☐ Change in position ☐ Other: _____

Which activities increase your symptoms? Please circle

Sitting	Walking	Twisting	Bending	Squatting	Stairs	Rising from chair	Pushing/pulling
Standing	Kneeling	Reaching	Lifting	Reclining	Other:		

Are you able to continue working? ☐ Yes, full duty ☐ Yes, light duty ☐ No_ Last day worked: _____

Are you able to continue your usual recreational activities? ☐ Yes ☐ No ☐ Limited - Explain: _____

What specific activities, at home or work, are you unable to perform? _____

Have you experienced any of the following with your current problem? Please circle

Locking	Giving way	Unconsciousness	Lip numbness	Dizziness/blurred vision	Incontinence/difficulty urinating
Buckling	Dislocating	Loss of balance	Dropping things	Pain with cough/sneeze	Numbness around groin or buttocks

How is your condition progressing overall? ☐ Improving ☐ Staying the same ☐ Getting worse

Please Complete Other Side