balance
REHABILITATION AND
HEALTH SCIENCE, LLC

Patient Information Record

Extremity

Name: _____

MD:_____

Date: _____

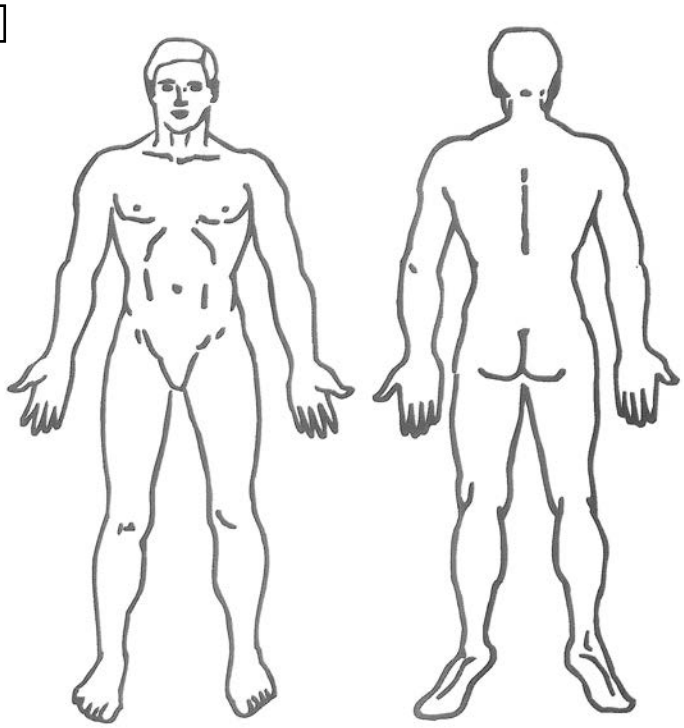
Age: _____Height:_____Weight:_____

HISTORY OF INJURY:

1. What is your primary complaint?_____Left or Right?_____
2. How and when (date) did the present symptom(s) occur?_____
3. A. Precisely where did the pain start? (please indicate on diagram) **X = numbness** **P = where pain started**
   B. Where did the pain spread? (please indicate on diagram) **T = tingling** **R = where pain spread**
4. On a scale of 0-10 (10 being excruciating) how painful was it:
   A. When it started?
   B. At it's best?
   C. At it's worst?
   D. How is it today?
5. Did you undergo surgery? Yes ☐ No ☐ If yes, what was the date of surgery?
6. How long were you hospitalized?_____
7. Describe your symptoms, does it throb ☐ twinge ☐ burn ☐ give you numbness/tingling ☐
8. What activities make your pain worse? _____
9. Can you get comfortable at night? Yes ☐ No ☐
10. Do you have any back pain now or any history of back pain? Yes ☐ No ☐
11. Do you have any problems with your bowels or bladder? Yes ☐ No ☐
12. What is the effect of coughing? Worse ☐ Better ☐ Same ☐
13. How does your problem feel on rising in the morning?
    Stiff ☐ Sore ☐ Fine ☐
14. Once you start moving about, does it:Worsen ☐ Ease ☐ Same ☐
15. What is it like at the end of the day compared to the beginning?
    Worse ☐ Better ☐ Same ☐
16. Have you ever had this problem before? Yes ☐ No ☐
    A. Is it increasing frequency? Yes ☐ No ☐
    B. Increasing severity? Yes ☐ No ☐
    C. Are your symptoms changing in character? Yes ☐ No ☐
    D. If yes, please describe
    E. Can you identify what causes it? If so what? Yes ☐ No ☐

    _____

    F. What did you do to resolve it?_____
17. Have you undergone a diagnostic medical test for this? Yes ☐ No ☐
    If so where?_____



R **L** **L** **R**

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1. MEDICAL HISTORY (circle one) DO YOU HAVE OR HAVE HAD:

Yes	No		Yes	No	
☐	☐	High blood pressure?	☐	☐	Impaired vision?
☐	☐	Heart disease or other cardiac condition?	☐	☐	Impaired hearing?
☐	☐	Angina (chest pain)?	☐	☐	Hepatitis?
☐	☐	Shortness of breath?	☐	☐	Asthma / or Allergies?
☐	☐	Lung disease?	☐	☐	Osteoporosis?
☐	☐	Stroke?	☐	☐	Bleeding Disorders?
☐	☐	Recent weight loss/gain?	☐	☐	Sleep Disturbances?
☐	☐	Unusual joint pain and/or swelling?	☐	☐	Diabetes?
☐	☐	Dizziness and/or a History of falls?	☐	☐	Depression?
☐	☐	A history of fractures?	☐	☐	HIV/AIDS?
☐	☐	A history of cancer?	☐	☐	Arthritis?
☐	☐	Increase in frequency or intensity of headaches?	☐	☐	Seizures?
☐	☐	Are you now, or do you have any reason to believe you may be pregnant?			

2. Please rate on a scale of 0-10 how painful the following activities are; use space provided for additional comments.

Rolling over in bed _____ Ascending/descending stairs _____

Transfer to/from bed _____ Transfer to/from car _____

Bathing _____ Driving _____

Dressing _____ Walking _____

Grooming _____ Sitting _____

Carrying _____ Standing _____

Household Cleaning _____ Bending _____

Reaching level/overhead _____ Lifting _____

Meal preparation _____ Child Care _____

Using the phone _____ Other _____

3. Please list ALL medications, dosage and purpose.

_____

_____

4. Please list all surgeries and approximate dates. _____

_____

5. Please indicate diagnostic tests for this problem. _____

_____

6. Have you seen anyone else for your current problems? If so, please list. _____

_____

Consent to Medical Treatment

I, _____, voluntarily consent to diagnostic procedures and related medical treatment as recommended by my physical therapist and their designees, and acknowledge that no guarantees have been or can be made as to the result of such treatments. This questionnaire is considered a part of your confidential medical record.

Signature_____ Date_____

Email_____

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