

## Patient Information Record Extremity

Name:	 	 
MD:	 	 
Date:		

HISTORY OF INJURY:  1. What is your primary complaint?  2. How and when (date) did the present symptom(s) occur?  3. A. Procisely 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) 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 I 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  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  If so where?  17. Have you undergone a diagnostic medical test for this? Yes No  If so where?		HABILITATION AND ALTH SCIENCE, LLC	Age:	Height:	Weight:	
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	Yes	No		Yes	No			
			High blood pressure?			Impaired vision?		
			Heart disease or other cardiac condition?			Impaired vision:  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?	-l 0		Arthritis?		
			Increase in frequency or intensity of headac		nt2	Seizures?		
			Are you now, or do you have any reason to	believe you may be pregna	III.?			
2.	Please ra	te on a	a scale of 0-10 how painful the following activit	ies are; use space provided	for ad	ditional comments.		
	Rolling ov	er in b	oed	_ Ascending/descending st	airs			
	Transfer	to/fron	n bed	_ Transfer to/from car				
	Bathing _			Driving				
	Dressing			Walking				
	Grooming	9		Sitting				
	Carrying			Standing				
	Househol	d Clea	ning	Bending				
	Reaching	level/	overhead	_ Lifting				
	Meal prep	paratio	n	_ Child Care				
	Using the	phone	e	Other				
3.	Please lis	t <u>ALL</u> r	medications, dosage and purpose.					
4.	Please lis	t all su	urgeries and approximate dates.					
٠.	1 10430 113	t an so	angeries and approximate dates.					
5.	Please inc	dicate	diagnostic tests for this problem.					
6.	Have you	seen	anyone else for your current problems? If so, p	olease list.				
Coı	nsent to N	/ledica	al Treatment					
Ι, _			y physical therapist and their designees, and a	onsent to diagnostic proced	ures ar	nd related medical treatment as		
rec res	ommended ult of such	by m treatn	y physical therapist and their designees, and a nents. This questionnaire is considered a part	cknowledge that no guaran of your confidential medical	tees ha I record	ive been or can be made as to the I.		
Sig	nature				Date.			
Em	ail							
		(	Christopher Pierce MSPT, CSCS   cpierce@balance-rehab.com	Peter Olson, MPT, OMT, ATC	polson	@balance-rehab.com		

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