

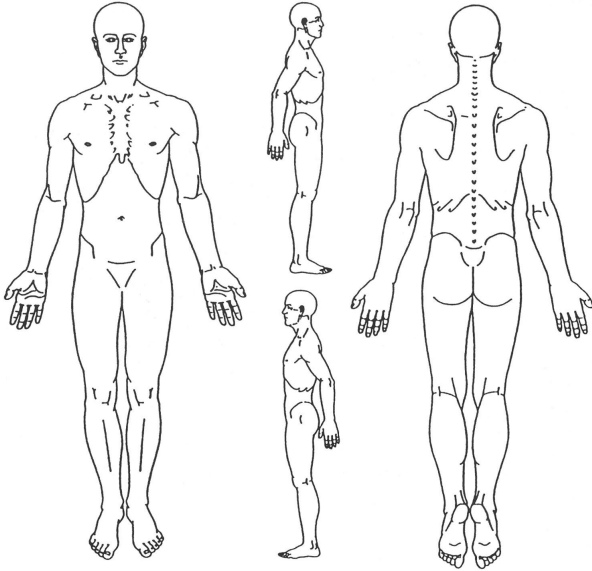
CONDITION HISTORY

Name _____

Date _____

PLEASE FILL IN THE APPROPRIATE SPACES (All information is confidential):

I. On the diagram below, indicate your 1st area of discomfort.



Describe the onset of your symptoms.
 Sudden Gradual

When did symptoms begin? _____

What is the status of your symptoms?
 Getting better
 Getting worse
 Staying the same

Is there any particular movement or activity that makes the pain worse? Yes No

If yes, explain. _____

What have you done to help your condition?

Did it help? Yes No Temporarily

II. Rate your pain as you answer the following questions.

How bad does it hurt on average?
 Indicate the intensity of your symptoms.
 0—1—2—3—4—5—6—7—8—9—10

How often do you experience symptom?
 while awake?

5%	30%	55%	80%
10%	35%	60%	85%
15%	40%	65%	90%
20%	45%	70%	95%
25%	50%	75%	100%

Describe the quality of your discomfort.
 Dull Deep Stinging
 Ache Throbbing Burning
 Sharp Tightness Numb/Tingling
 Shooting Tender _____

Is there any time of day that it is worse?
 None Morning Afternoon
 Evening Night Other: _____

What hobbies or activities of daily living are being affected by this condition?

1. Name any other doctors you have seen for this condition: what was done & for how long?

Were diagnostic tests or imaging ordered (X-ray, CT, MRI, Ultrasound, etc) Yes No

List the procedures & date: _____

2. Have you had this or a similar condition before? Yes No When? _____

3. Have you lost work days? Yes No How many? _____

4. Was the injury related to Work accident Auto accident?