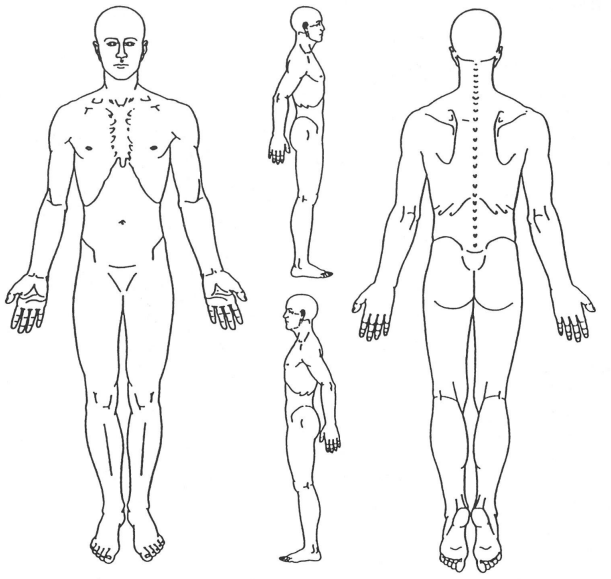
CONDITION HISTORY

Name _____ **Date** _____

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

I. On the diagram below, indicate your other 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?