Comprehensive History Questionnaire

Reviewd by: _______________
Blood Pressure: ____________
Pulse: ____________________
Temp: ____________________
Shoe Size: _____ **Width:** _____

Name: ____ Date: ____________________

Age: ______ Height:______ Weight:______ Occupation:_______________________________

Referred to our office by: ____

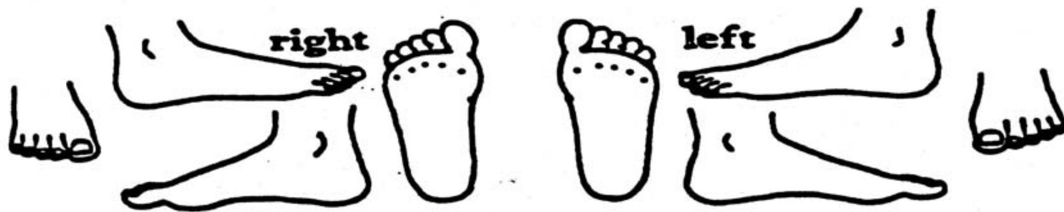
Chief Complaint: (brief description of your current orthopedic problem) **Please Circle: Left, Right, or Both**

____

____

History of Present Illness: (answer these questions regarding your current problem(s) only)

(indicate area of pain on the diagram below)



What symptoms are you experiencing? ____

____

How long have you had this problem? ____

Have you had similar pains in the past? YES NO If yes, when? _______________________________________

How did it happen? ____

Injury? YES NO If yes, give date: ___________________

Where did it occur? _____________________________________

Work related? YES NO If yes, give date of injury: ______________________________

How many work-days have you missed? _______________________________________

Are you working now? YES NO

Have you had previous work-related injuries? YES NO If yes, when? ___________________

How severe is this for you? (Circle below)

No pain (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Worst pain of your life

What makes it worse? (eg. sitting, standing, walking, exercise) ____

____

What makes it better? (eg. lying, sitting, standing, walking, exercise, mediations OTC/Prescribe)______________________________

____

Give previous treatment for this problem? (eg. emergency room, physical therapy, chiropractic or other alternative treatments)

____

____

Have you had any of the following diagnostic studies for your current problem?

Diagnostic X-rays	yes	no	Date: ________
CT (computed tomography)	yes	no	Date: ________
MRI (magnetic resonance imaging)	yes	no	Date: ________
Epidural Steroid/ Facet Block injection	yes	no	Date: ________
EMG (electromyogram)/ NCV (nerve conduction velocity	yes	no	Date: ________