Comprehensive History Questionnaire

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

Name: _____ Date: _____

Age: _____ Height:_____ Weight:_____ Occupation:_____

Referred to our office by: _____

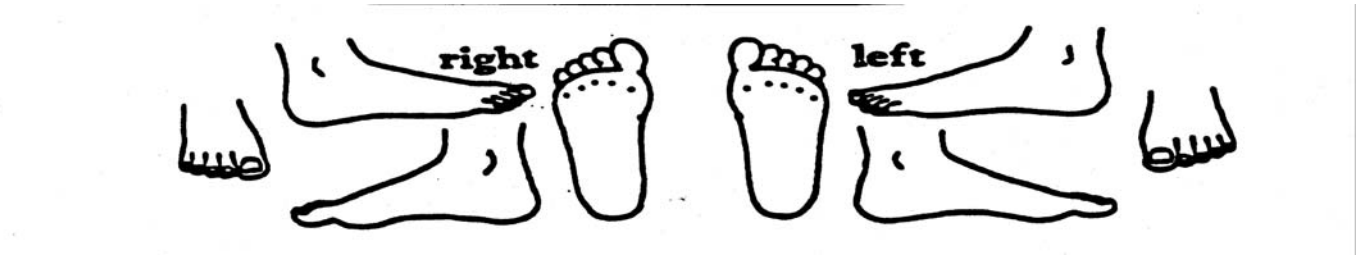
Chief Complaint: (brief description of your current orthopedic problem) **Please Circle: Left, Right, or Both**

_____

_____

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: _____