

PATIENT HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.

Name _____ Birthday _____ Sex M F

Address _____ City _____ Zip _____

Please describe in your own words any pain or symptoms you may be experiencing:

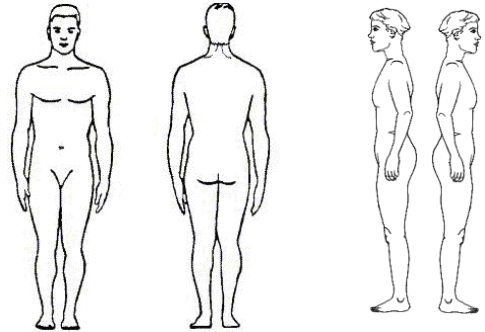
Please show us where your symptoms are by marking the body to the right:

Type(s) of Pain:

- Numbness/Tingling
- Dull/Aching/Throbbing
- Sharp/Stabbing
- Swelling
- Stiffness
- Burning
- Other _____

Frequency:

- Occasional 0-25%
- Intermittent 26-50%
- Frequent 51-75%
- Constant 76-100%



Severity:

Least Pain 1 _____ 10 Most Pain

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

Do any positions make it feel worse? _____

Do any positions make it feel better? _____

Is this condition interfering with your: Work Sleep Daily Routine Other _____

Other doctors or therapists who have treated THIS condition: _____

What do you think caused this condition? _____

Signature _____ Date _____

Parent/Guardian _____ Date _____