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|  |  | **1509 West Orange Blossom Trail, Apopka, FL 32712 Phone: (407) 814-0436 Fax: (407) 814-0818**  |

**History Questionnaire**

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| --- | --- |
| Name: | Date: |
| Contact Telephone Number: | E-mail Address: |
| Home Address: |
| Emergency Contact and Phone Number: |
| Date of Injury or symptoms:\_\_\_\_*/*\_\_\_\_\_*/*\_\_\_\_mm dd yy | Description of injury or symptoms: |
| Date of Surgery:\_\_\_\_*/*\_\_\_\_/\_\_\_\_mm dd yy | Have you had this pain or problem before? YES NO | Is your pain on the surface or deep? Deep Surface |
| Medications: (include all medications) |
| Medical History

|  |  |  |  |
| --- | --- | --- | --- |
| Allergies  | O Yes O No | Depression  | O Yes O No |
| Anemia  | O Yes O No | Diabetes  | O Yes O No |
|  Anxiety  | O Yes O No  | Dizzy Spells | O Yes O No |
| Arthritis  | O Yes O No | Emphysema/Bronchitis | O Yes O No |
| Asthma  | O Yes O No | Fractures | O Yes O No |
| Cancer  | O Yes O No | Gallbladder Problems | O Yes O No |
| Cardiac Conditions  | O Yes O No | Hepatitis | O Yes O No |
| Cardiac Pacemaker  | O Yes O No | High Blood Pressure | O Yes O No |
| Chemical Dependency | O Yes O No | Incontinence | O Yes O No |
| Circulation Problems  | O Yes O No | Kidney Problems | O Yes O No |
| Currently Pregnant  | O Yes O No | Metal Implants | O Yes O No |

|  |  |
| --- | --- |
| Multiple Sclerosis | O Yes O No |
| Osteoporosis | O Yes O No |
| Parkinsons | O Yes O No  |
| Rheumatoid Arthritis | O Yes O No  |
| Seizures | O Yes O No  |
| Speech Problems | O Yes O No  |
| Strokes | O Yes O No |
| Thyroid Disease | O Yes O No  |
| Tuberculosis | O Yes O No  |
| Vision Problems | O Yes O No  |

Please list any other or surgical conditions: |
| Where is your pain? 🞏 Neck 🞏 Low Back 🞏 Middle Back 🞏 Shoulder Blade🞏 Shoulder 🞏 Elbow 🞏 Wrist 🞏 Chest 🞏Hip🞏 Knee 🞏 Ankle 🞏 Foot 🞏 Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What activities are you having problems with due to this problem? (ex. Walking, reaching, sitting, standing, lifting…) |
| What makes your pain worse? |
| What makes your pain better? |
| Do you have any numbness or tingling? Where? |
| On a scale of 1 to 10, What would you rate your worst pain to be? \_\_\_\_\_/10  Mild discomfort Moderate Unbearable/Severe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 5 10 |
| On a scale of 1 to 10, What would you rate your pain to be now? \_\_\_\_\_/10  Mild discomfort Moderate Unbearable/Severe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 5 10 |
| On a scale of 1 to 10, What would you rate your best pain to be? \_\_\_\_\_/10  Mild discomfort Moderate Unbearable/Severe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 5 10 |
| Use the key below to mark the areas of the body where you are having problems: Pain Key: OOOO Pins and needles XXXX Burning ///////// Stabbing ==== Dull Ache  PPPP Other – describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

Patient Name

Signature Date