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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