PATIENT: _____

MEDICAL HISTORY/BODY/PAIN CHART AND ADL SCREEN

Diagnosis as stated to you by your physician:_____ Date of onset?_____
How did this injury/exacerbation occur? _____
Have you been hospitalized for the present condition? ☐Yes ☐No If Yes, date: _____
Have you had surgery for the present condition? ☐Yes ☐No If Yes, date: _____
Have you received previous treatment for this condition? ☐Yes ☐No If Yes, date: _____
If yes, please summarize:_____
Are you currently receiving or have you received in the last 30 days any other home health, medical or chiropractic services rendered to you by any other agency, organization or individual? If yes, please summarize:

_____
Are you on any medications? Please list (you may use reverse side) _____
Have you ever had any of the following? ☐EMG ☐CAT SCAN ☐MYELOGRAM ☐ MRI ☐XRAY

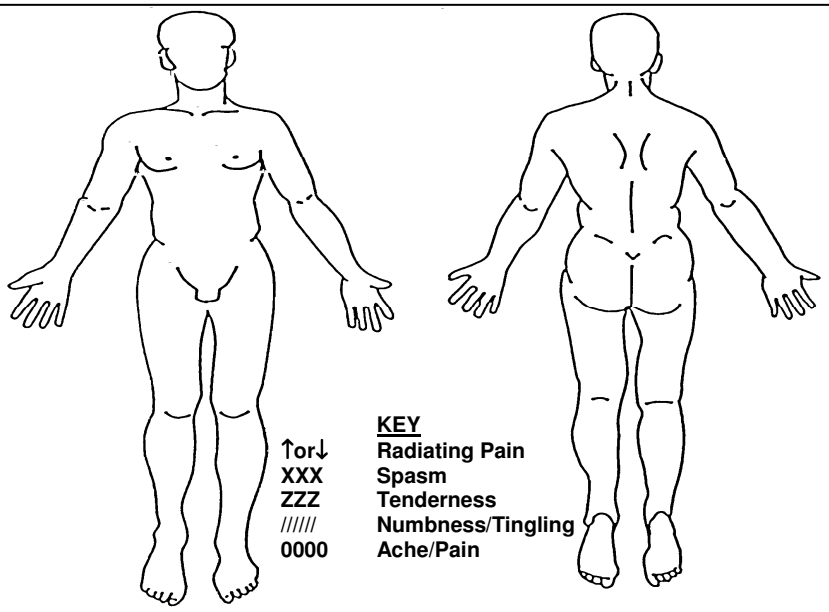
Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	☐Yes	☐No
Headaches	☐Yes	☐No
Dizzy Spells	☐Yes	☐No
Fainting Spells	☐Yes	☐No
Epilepsy	☐Yes	☐No
Stroke	☐Yes	☐No
Pregnancy	☐Yes	☐No
Seizures	☐Yes	☐No
Asthma	☐Yes	☐No
Emphysema	☐Yes	☐No
Osteoporosis	☐Yes	☐No
Back Injury	☐Yes	☐No
Arthritis	☐Yes	☐No
Bleeding Disorder	☐Yes	☐No
Fracture	☐Yes	☐No
Cancer	☐Yes	☐No
Pacemaker	☐Yes	☐No
Metalology (implants)	☐Yes	☐No
Respiratory Problems	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Hepatitis A, B, C	☐Yes	☐No
Heart Trouble	☐Yes	☐No
High Blood Pressure	☐Yes	☐No
Allergies	☐Yes	☐No
list:_____		
Other:_____		

Please circle all that may apply. My pain is worse:
In the morning/during the day/at night/constant/with activity/during rest

On a scale of 0 to 10,
(0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain at its best_____ and at its worse_____

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.



As it relates to your current problem, are you unable to or have difficulty with performing any of the following activities? Do you have pain associated with or have you changed your method of performing any of the following tasks? Check all that apply.

☐ Getting in/out of bed	☐ Personal hygiene activities	☐ Eating	☐ Shaving	☐ Cleaning
☐ Getting in/out of a car	☐ Bathing/Shower	☐ Sleeping	☐ Lifting	☐ Writing
☐ Getting in/out of a chair	☐ Brushing teeth	☐ Sitting	☐ Cooking	☐ Shopping
☐ Walking up/down stairs	☐ Dressing	☐ Standing	☐ Laundry	☐ Driving
☐ Getting in/out of shower	☐ Work Activities	☐ Walking	☐ Vacuuming	

☐ Other: _____

Patient's Signature: _____ Date: _____

I have reviewed the above information

Therapist Signature: _____ Date: _____

01/24/2006