LvW Physiotherapy

LvW

Name: Date: :

Referring Physician:______________________________ RIZIV-INAMI #:___________________________

Insurance:_______________________________________ Date of Birth:____________________________

Date of Prescription:______________________________ Contact phone #:__________________________

Vitals: BP: HR:

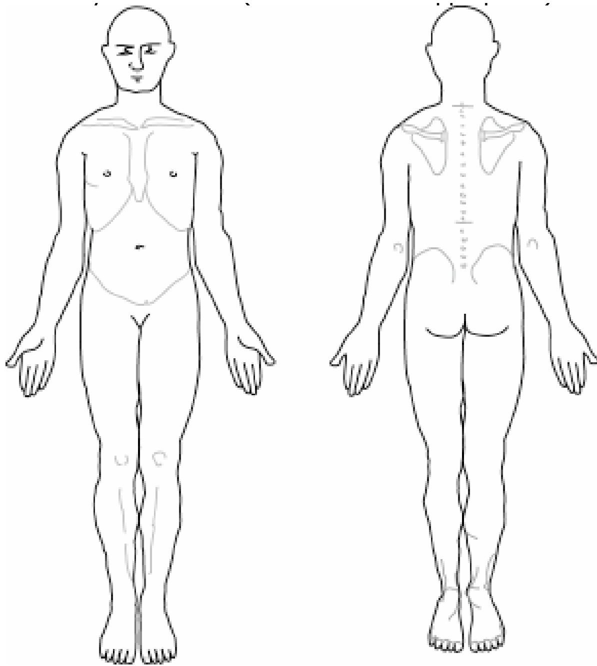
HISTORY OF PRESENT CONDITION

1. What are your symptoms? ______________________________

____

____

Localize areas of **pain** or **abnormal** sensation on the body chart below
(Shade in where appropriate)



2. When did your symptoms begin?
(Please indicate a specific date if possible)________________

3. Was the **onset** of this episode gradual or sudden?(Check one)
(1) gradual (2) sudden

4. Which of the following **best describes** how your injury occurred?
(if your condition is post-surgical please indicate as per original injury)
(1) lifting
(2) a MVA (car accident)
(3) a fall
(4) overuse (cumulative trauma)
(5) trauma
(6) degenerative process
(7) during recreation/sports
(8) running
(9) a blow to the face
(10) being hit by a ball
(11) a dental appointment
(12) throwing
(13) an incident at work
(14) unknown
(15) other ____________

5. Since onset, are your symptoms getting: (Check one)
(1)better (2) worse (3) not changing

6. Have you had similar symptoms in the past? (1) Yes (2) No
More than one episode? (1) Yes (2) No

7. As the day progresses, do your symptoms: (Check one)
(1) increase (2) decrease (3) stay the same

8. Nature of pain/symptoms (check all that apply)
(1) sharp (4) aching (7) constant
(2) dull (5) periodic (8) other _______
(3)throbbing (6) occasional ________________

9. Does the pain wake you at night? (1) No (2) Yes
if "yes", is it present (1) while lying still
(2) only when changing positions
(3) both

10. Do you have pain/stiffness upon getting out of bed in the morning? (1) Yes (2) No

11. In what position do you sleep? (Check all that apply)
(1) right side (4) back (6) back, sides, stomach
(2) left side (5) chair/recliner (7) other ___________
(3) stomach

12. Since the onset of your current symptoms have you had:
(1) any difficulty with control of bowel or bladder function
(2) fever/Chills
(3) any numbness in the genital or anal area
(4) numbness
(5) any dizziness or fainting attacks
(6) weakness
(7) unexplained weight change
(8) night pain/sweats
(9) malaise (vague feeling of bodily discomfort)
(10) problems with vision/hearing
(11) none of the above

13. What aggravates your symptoms? (Check all that apply)
(1) sitting
(2) going to/rising from sitting
(3) lying down
(4) walking
(5) up/down stairs
(6) reaching overhead
(7) reaching in front of body
(8) reaching behind back
(9) reaching across bod
(10) looking up overhead
(11) stress
(12) recreation/sports including
____
(13) repetitive activities
including______________
(14) Household activities
including______________
(15) standing
(16) squatting
(17) sleeping
(18) coughing/sneezing
(19) taking a deep breath
(20) swallowing
(21) talking, chewing, yawing
(22) sustained bending
(23) other______________

14. What relieves your symptoms? (Check all that apply)
❒ (1) sitting
❒ (2) heat
❒ (3) cold
❒ (4) stretching
❒ (5) wearing a splint/orthosis
❒ (6) rest
❒ (7) standing
❒ (8) walking
❒ (9) exercise
❒ (10) lying down
❒ (11) massage
❒ (12) medication
❒ (13) nothing
❒ (14) other_______
____

15. Have you had any previous treatment for this condition before?

(Including medication, injections, bracing, hospitalization)

____

Did it help? ____

16. Have you had any imaging done? _______________________

If yes, what and what was the results ________________________

____

17. Please list at any medication you are currently taking.

____

____

18. Do you have any allergies to food, medication, other? ______

If yes, what kind? ____

____

19. Do you have mold, metals, toxins, pesticides, dust in your home or work place? ______________________________________

20. Do you take any supplements?___________________________

21. Do you have any gastrointestinal symptoms? (gas, bloating, constipation, diarrhea)____________________________________

22. Do you feel fatigued? ________________________________

23. Do you have areas that have not healed well? ______________

If Yes, where____

24. Do you label these areas as your "Bad" knee, shoulder, neck?

____

25. How many hours do you sleep? ___________________________

26. Do you feel you sleep well? ______________________________

27. Do you sleep on your stomach, side, back?_________________

28. Do you have problems sleeping well? _____________________

29. How many alcohol drinks do you have a day? ______________

A weeK? ____

30. Do you smoke? _____________ packs/day ________________

31. Do you drink caffeine? _________ drinks/day____________

32. How much stress is in your life? __________________________

33. How do you unload your stress? _________________________

____

34. Have you had any surgeries? ____________________________

____

35. What scars do you have? _________________________________

____

36. Do you exercise? ___________________________

If yes, how often and what do you do? __________________________

____

____

37. Have you had any head injuries? ___________________________

38. Have you ever had/been diagnosed with any of the following? (Please circle)

cancer (type) _____________ Depression Anxiety

Multiple Sclerosis Kidney problems Thyroid problems

Diabetes Arthritis Stomach problems Adrenal Problems

Heart Problems Blood disorders Rheumatoid arthritis

Osteoporosis Irritable bowel syndrome Gout Chron's

Vascular/Peripheral problems Other_______________

39. Do you have or have you had every had any infection disease? (i.e. hepatitis, Tuberculosis, AIDS, etc) ______________________

40. Has anyone in your immediate family (parents, brother, sisters) ever been treated for any of the following? Please circle

Diabetes Cancer Heart disease

High blood pressure Arthritis stroke

Psychological condition Other____________________