

HISTORY OF PRESENT ILLNESS

To help us meet your healthcare needs, please fill out this form completely.

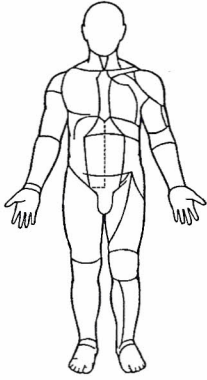
Date _____

Patient Name _____ DOB _____ Age _____

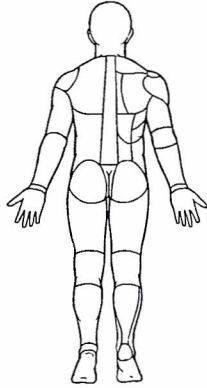
Gender M F

Reason For Visit _____

Location Of Problem/Pain (Please place X's on Figure At Below)



Right Left



Left Right

Circle Pain Level Today: (0 = none 10 = worst)

0 1 2 3 4 5 6 7 8 9 10

How Many Days You Have Pain In The Week?

1 2 3 4 5 6 7

Level Of Pain On Worst Day: (0 = none 10 = worst)

0 1 2 3 4 5 6 7 8 9 10

Date Problem First Started _____ Place Of Injury (If Applicable) _____

Is Condition Related To Illness Employment Auto No Accident Other Accident _____

Was Onset Of Symptoms Sudden Gradual Pain Has Been Present For: ____ Days ____ Weeks ____ Months ____ Years

How Problem Started _____

What Symptoms Do You Have Today? Pain Swelling Tenderness Numbness Tingling Stiffness
 Weakness Mass or Lump Popping Locking Burning _____

Where Is The Pain Located? Please be specific. _____

What Does The Pain Feel Like? (Check All That Apply) Sharp Dull Aching Stinging Throbbing Burning

When Are Symptoms Present? All The Time During Activity After Activity Occasionally Rarely
 Comes & Goes With Weather Changes In Morning In Evening At Night

What Makes The Symptoms Worse? Sitting Standing Walking Bending Lifting Twisting Climbing Stairs
 Going Down Stairs Lying Down Activity Reaching Pulling Carrying Any Movement

What Makes The Pain Better? Rest Ice Heat Medication Brace _____

Does The Pain Wake You Up At Night? Yes No

Treatment You Have Received For This Problem: Went To The Emergency Room

MRI CT X-Rays Physical Therapy Nerve Conduction Study Epidural Steroid Injection

Injections Surgery - Date Performed _____ Other _____

Medicine: Please List: _____

Has Your Condition Changed With The Prior Treatment: Unchanged Slightly Better Improved Worse

