Name:	**Weight:**	**Date of Injury/onset of condition:**
Age:	**Height:**	

Occupation: ____

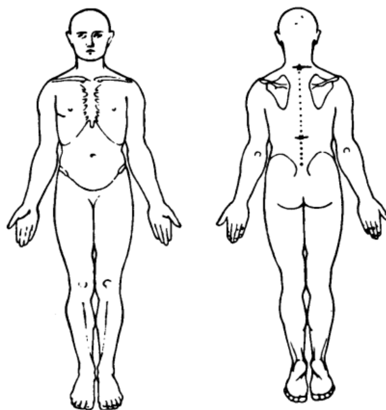
Currently working? ☐ Yes ☐ No **Work restrictions?** ☐ Yes ☐ No : ____________________

How and where did your injury or condition begin? ______________________________

Is your condition: ☐ Getting better ☐ Getting worse ☐ Fluctuating ☐ Staying the same

Have you had previous injury to this area? ☐ Yes ☐ No :______________________

Please mark your area of symptoms



Symptoms (check all that apply)

- ☐ Pain
- ☐ Numbness
- ☐ Tingling
- ☐ Weakness
- ☐ Stiffness
- ☐ Swelling
- ☐ Difficulty walking
- ☐ Unstable joint
- ☐ Pain that wakes you at night
- ☐ Pain with coughing/sneezing
- ☐ Change in bowel/bladder function
- ☐ Dizziness/nausea

Rate your PAIN:

0 to 10: (0= no pain, 10= unbearable pain)

Worst: ________ Current: _______ Best: ________

Diagnostic testing:

☐ X-ray ☐ MRI ☐ CT scan

Findings: ______________________

____

General health (check all that apply)

☐ Cancer	☐ Tumors	☐ Pacemaker	☐ Currently Pregnant
☐ Diabetes	☐ High Blood Pressure	☐ Headaches	☐ Allergies
☐ Cardiac condition	☐ Metal implants	☐ Seizures	Other: ________________

Surgeries (date, procedure): ______________________________________

____

Medications: ____

____

What activities do you feel limited in?

☐ Sitting	☐ Stair climbing	☐ Sleeping	☐ Yard work/Gardening
☐ Standing	☐ Reaching	☐ Computer work	☐ Sports activities
☐ Walking	☐ Hand/arm use	☐ Driving	☐ Housework
☐ Lifting	☐ Squatting	☐ Other: ______________________	