

## GENERAL HEALTH AND SOCIAL HISTORY

Current Health Status: .....  Right handed  Left handed  
 Occupation: ..... Marital Status: S M D W Number of Children.....  
 Family Physician: ..... Telephone: .....  
 Other Physicians: ..... Last Lab: .....  
 ..... Last X-ray: .....

List serious illnesses, fractures, surgeries or hospitalization (date and explain):  
 .....  
 .....  
 .....

List current medications	Strength	Dosage	Reason
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

List previous work injuries or motor vehicle accidents: .....  
 .....  
 .....

Circle and describe problems you have or have had in any of the following areas:

- |          |                  |            |              |                     |
|----------|------------------|------------|--------------|---------------------|
| 1. Skin  | 4. Lungs         | 7. Nerves  | 10. Blood    | 13. Ear/Nose/Throat |
| 2. Head  | 5. Stomach/Bowel | 8. Muscles | 11. Hormones | 14. Respiration     |
| 3. Heart | 6. Urinary       | 9. Bones   | 12. Growth   | 15. Immunity        |

Explanation: .....  
 .....

Do you have blood relatives with a history of any of the following conditions? Relation? Age?	Personal habits:	yes	no
Arthritis/Gout .....	Recent weight change	.....	.....
Cancer .....	Alcohol use	.....	.....
Heart attack .....	Recreational drug use	.....	.....
Stroke .....	Tobacco use	.....	.....
Other .....	Please describe: .....	.....	

Information we need for Physiotherapy:

Are you pregnant? Yes No Date of last menses: .....  
 Do you have implants? Yes No (Joint replacement, pins/screws/wires/rods/plates, IUD, pacemaker)  
 Cancer? Yes No Describe: .....

Patient Signature: ..... Doctor Signature: .....

## CURRENT COMPLAINT

Patient Name: .....

Age: ..... Today's Date: .....

Check and describe area(s) of complaint:

- |                                     |                                   |                                |
|-------------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Head       | <input type="checkbox"/> Shoulder | <input type="checkbox"/> Hip   |
| <input type="checkbox"/> Neck       | <input type="checkbox"/> Arm      | <input type="checkbox"/> Leg   |
| <input type="checkbox"/> Upper Back | <input type="checkbox"/> Elbow    | <input type="checkbox"/> Knee  |
| <input type="checkbox"/> Mid Back   | <input type="checkbox"/> Wrist    | <input type="checkbox"/> Ankle |
| <input type="checkbox"/> Low Back   | <input type="checkbox"/> Hand     | <input type="checkbox"/> Foot  |

It developed from:

- Work-related activity
- Activity other than work
- Auto accident (Date: .....) )
- An Injury (Date: .....) )
- Other .....

Describe the complaint: .....

How did it happen? .....

Have you had this problem before?  Yes  No If yes, when? .....

Have you seen other doctors for this complaint?  Yes  No

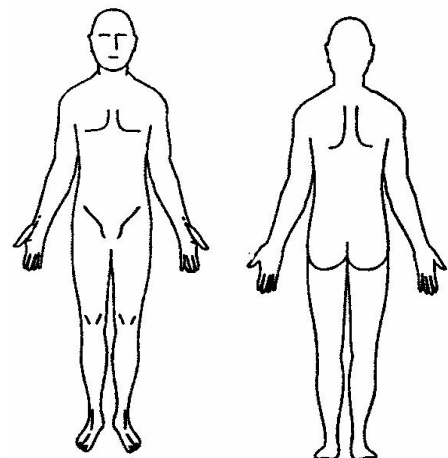
Name and telephone of doctor(s): .....

Can you perform the following activities?

- |                                      |   |                       |
|--------------------------------------|---|-----------------------|
| ..... coughing or sneezing           | U = unable P = painful D = difficult L = limited N = normal | ..... sleeping        |
| ..... getting in and out of a car    | ..... bending over forward                                  | ..... stooping        |
| ..... bending forward to brush teeth | ..... turning over in bed                                   | ..... pushing         |
| ..... walking a short distance       | ..... sitting at a table                                    | ..... pulling         |
| ..... standing more than 1 hour      | ..... dressing yourself                                     | ..... climbing stairs |
| ..... lying on side with knees bent  | ..... sexual activities                                     | ..... reaching        |
| ..... lying flat on your back        | ..... balancing   | ..... gripping        |
| ..... lying flat on your stomach     | ..... kneeling  | ..... running         |
|                                      | ..... brushing your hair                                    |                       |

Are you able to perform your employment duties?  Yes  No

Please indicate areas of pain or discomfort:



- P = pain
- X = deep ache
- = tingling, pins and needles
- / = sharp or burning
- S = spasm

Check other symptoms:

- Blurring vision
- Dizziness
- Fainting
- Confusion
- Convulsions
- Loss of sleep
- Muscle jerking
- Numbness
- Tingling
- Weakness
- Buzzing or ringing in the ears
- Depression or crying spells
- Headaches How often? .....

Continued on other side