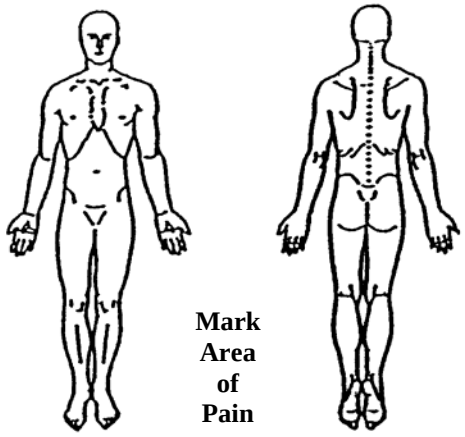
MEDICAL HISTORY

PATIENT NAME:_____**DATE:**_____

IF YOU ARE NOT IN PAIN, please list your current complaints below. **IF YOU ARE IN PAIN**, mark area of pain on diagram and describe.



When were you first aware of the problem(s)?								
What caused the problem(s)?	specific incident		multiple incidents		gradual onset		no reason	
Have you received treatment for the problem(s)?	yes	no	**If yes, where, when, results?**					
Have you previously experienced similar symptoms?	yes	no	**If yes, when ?**					
Were you treated previously for similar symptoms?	yes	no	**If yes, where, when, results?**					
Has/Have problem(s) been getting/staying	better	worse	same	**Comments:**				
What makes your problem better?	nothing	lying down	walking	standing	sitting	movement	inactivity	food intake
What makes your problem worse?	nothing	lying down	walking	standing	sitting	movement	inactivity	food intake
How would you rate your level of stress?	no stress		minimal stress		moderate stress		severe stress	
Describe your physical activities at work:	sit 50+% of time		stand 50+% of time		light labor		heavy labor	
Describe your regular physical activity/exercise:	none		light		moderate		strenuous	
What aspects of your life have been affected?	home life		work life		recreation		rest / sleep	
Describe the affects on your life:								
Do you need assistance with everyday tasks?	yes	no	**Comments:**					
Do you need assistance often?	yes	no						
Can you function without assistance?	yes	no						
Do you have any physical restrictions?	yes	no						
Are you able to work?	yes	no						
Any accidents, injuries or illnesses NOT reported above?								
Are you pregnant?	yes	no	**Date of last menstrual period:**					
CURRENT DRUGS and PAST SURGERIES:								

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