History of Current Health Condition

Name	Date	Patient No.

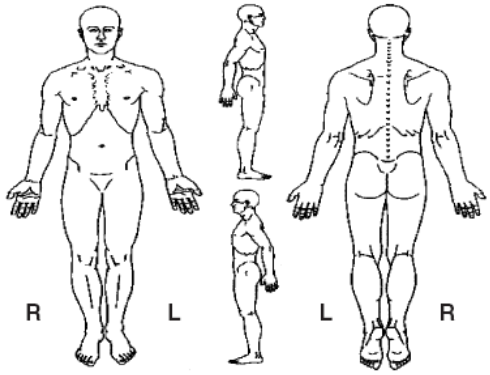
This column is for Office Use Only

Current Complaint(s): _____
Other Doctors/Therapists seen for this condition: □ Yes □ No
Who? _____ Type of Treatment: _____ Results: _____
_____ _____ _____
When did this condition begin? _____ Has it occurred before? □ Yes □ No
Is the condition:
□ Acute □ Chronic □ Gradual/Insidious □ Home accident □ Sports injury □ Work/Auto injury
□ Other:_____ Date of Accident: _____ Time of Accident: _____
Describe the circumstances when your condition began:_____
_____
_____
What aggravates your condition? □ Sitting □ Standing □ Bending □ Lifting □ Lying down
□ Specific activity: _____
What relieves your condition? □ Ice □ Heat □ Bed rest □ Massage □ Medication
□ Other: _____
Is it getting: □ Worse □ Constant □ Comes / Goes □ Better
How would you describe it? □ Sharp □ Dull □ Ache □ Pins & Needles □ Numb
□ Burning □ Constant □ Intermittent □ Other:_____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING:

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - - - - -	0 0 0 0 0 0 0 0 0	X X X X X X	+ + + + + + +	/ / / / / / / / /



What is your pain RIGHT NOW?

No Pain _____ Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

Compare this problem at its worst with a time when you feel great. How does this problem at its worst interfere with: Your ability to work? _____
Your ability to enjoy your family or social time? _____
Your ability to enjoy your hobbies or sports? _____
Medications you now take: □ Pain Killers □ Muscle Relaxants □ Blood Pressure Medicine □ Insulin
□ Anticoagulants □ Others: _____
Do you suffer from any conditions other than that for which you are now consulting us or not otherwise described above? _____
_____

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Performance & Wellness Centre