

PERFORMANCE HEALTH AUSTIN

PATIENT HISTORY FORM – Page 1

Patient Name: _____ Patient DOB: _____ Date: _____

IF YOU HAVE MORE THAN ONE COMPLAINT, PRINT & COMPLETE THIS PAGE FOR EACH PROBLEM

Present Complaint: _____

History of Present Complaint:

When did your most recent problem begin? _____

How did it begin?

- Immediately after a specific event Multiple events
- Gradually developed No apparent reason

Briefly describe any details: _____

Is your pain constant intermittent only w/ movement

Is your pain improving worsening not changed

Have you had this problem before? Yes No When? _____

What makes your problem better? _____

What makes your problem worse? _____

Rate your pain level: **now** ____/10 **At its worst** ____/10

No pain 0 1 2 3 4 5 6 7 8 9 10 Most intense pain imaginable

Is there anything else you feel might be related to this problem?

Prior tests: X-ray, MRI, CT, ultrasound, lab, other: _____

Prior treatment for this problem?

- None Physical therapy Chiropractic Acupuncture
- Massage Injections Surgery _____
- Medications (frequency/dosage) _____
- Other _____

What have you been told is wrong? _____

When was treatment and did it work? _____

FOR PROVIDER USE ONLY

yo _____

♂ ♀

WC/MVA _____

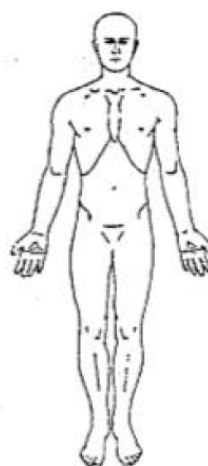
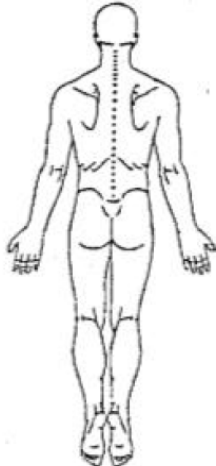
sitting/lifting _____

morning/valsalva _____

standing/walking _____

Fill out the pain drawing below using the following symbols:

>>>>> Ache □□□□ Numbness XXXX Burning ////////////// Stabbing 000000 Pins & Needles



DDX

CA _____
 Fx _____

