Patient Condition Form

Name: _____ Age: _____ DOB: _____

Occupation/Student: _____

Reason for visit: _____

When did your symptoms appear? _____ Is this condition getting worse? Y N

Rate severity of pain on a scale of 1 (least pain) - 10 (severe pain): _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Cramps ☐ Aching ☐ Tingling ☐ Shooting ☐ Burning ☐Stiffness ☐ Swelling ☐ Other_____

How often do you have this pain? _____

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreational activities

Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

Prior to the condition or injury, please rate your functional status with self-care and home management activities: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please rate your current functional status with self-care and home management activities:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you experienced any of the following?

☐ Changes in bowel/bladder ☐ Non-healing sores/wounds ☐ Fatigue

☐ Unexplained weight loss ☐ Referred or radiating pain ☐ Fever/sweats

☐ Pain worse at rest vs activity ☐ Unexplained lower or upper extremity weakness

Are you currently pregnant? Y N IF yes, what is your due date? _____

<u>Family/Social History:</u>

Do you live alone? Y N If no, with whom do you live? _____

What type of home ☐ 1 story ☐ 2 story ☐ Apartment ☐ Tri-level ☐ Other: _____

Are there stairs in the home or to get into home? Y N If yes, how many? _____

Are you currently working? Y N What is your occupation? _____

Do you smoke? Y N If yes, packs/day: ___ Do you drink alcohol? Y N If yes, drinks/week ___

Do you exercise? Y N If yes, how many times per week? _____

Have you received any of the following treatment(s) for your condition/injury?:

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic ☐ Other: _____

If yes to above, please describe: _____

Name and address of other doctors who have treated you for your condition: _____

_____

Have you had any diagnostic testing: ☐ X-ray ☐MRI ☐ CT Scan ☐ Bone Scan ☐ Other _____
If you have had testing, please provide dates: _____

Have you been diagnosed with any of the following conditions?

	Yes	No		Yes	No
Osteoporsis			Have a Pacemaker		
Cancer			Hearing or Visual Impairment		
Diabetes			Thyroid Problem		
Arthritis			Kidney Disease		
High Blood Pressure			Vertigo		
Circulatory Problems			History of Falls		
Depression			High Cholesterol		
Seizures			Contagious Disease		
Heart Problems			Stroke		

Please list any other injuries or diagnoses not listed above: _____

Please list all past injuries and/or surgeries you have had with dates: _____

_____

Are you currently taking over-the-counter medication, vitamins or supplements? Y N If yes, please list: _____

Are you currently taking prescribed medication? Y N If yes, please list: _____

_____