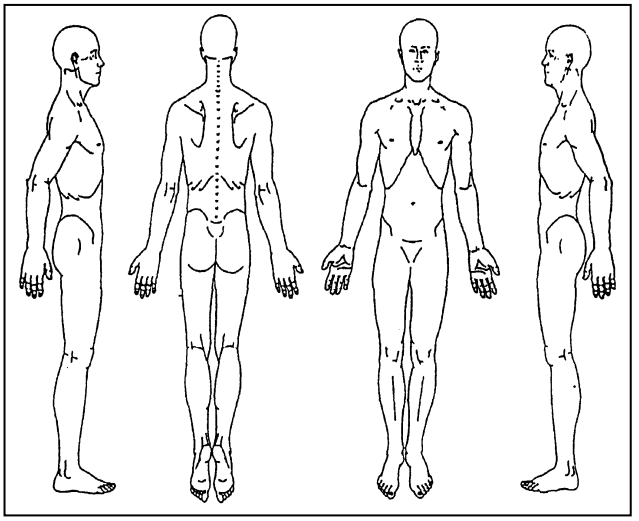
PATIENT HEALTH INFORMATION FORM

MARK PRIMARY PAINFUL AREA WITH AN X BELOW



REASON FOR TODAY'S VISIT:

1. **Primary** current complaint/problem we are seeing you for today:

_____

_____

2. Date when current injury / problem began (or date of surgery) ?

_____

3. **Briefly** describe how did current injury / problem occur?

_____

_____

_____

4. Did you have a recent X-ray and/or MRI performed on **this** body part/area? **Yes / No** Date/s_____

_____

5. List activities or positions that make the pain worse for this area:

_____

_____

6. List activities or positions that make the pain better for this area:

_____

7. Pain scale: (circle) **no pain = 0 1 2 3 4 5 6 7 8 9 10 = very severe/"get me to the ER"!**

8. Pain description: (circle all that apply) ***sharp dull achy tingle numb throbbing shooting stabbing burning radiating***

(or other/s please list/describe)_____

9. Have you ever received physical therapy care? **Yes / No** If yes, **When** and **What** problem/body area was treated?

_____

10. Are you currently receiving any form of home health services? **Yes / No** For **What**? _____

11. Job title/description: _____ Is this current injury work related? **Yes / No**

CHECK ANY OF THE SYMPTOMS THAT YOU CURRENTLY HAVE:

O Neck Pain	O Asthma	O Joint Swelling	O Chest Pains
O Neck Stiff	O Allergies	O Diabetes	O Shortness of Breath
O Pain in Hands or Arms	O Nervousness	O Menstrual Cramps	O Dizziness
O Irritability	O Stomach Upset	O Loss of Balance	O Pain between Shoulders
O Loss of Memory	O Constipation	O High Blood Pressure	O Shoulder Pain
O Depression	O Diarrhea	O Heart Attack	O Low Back Pain
O Sleeping Problems	O Loss of Smell or Taste	O Stroke	O Pain in Legs or Feet
O Pain Worse at Night	O Fatigue	O Headaches	O Fever
O Tension	O Numbness in Legs or Feet	O Lights Bother Eyes	O Weight Loss
O Sinus Pain	O Cancer or Tumors	O Numbness in Hands or Arms	

O Other (optional) _____

12. List any other previous major past medical history or major surgeries/& dates

_____

_____

13. Current Rx Medications: (if you have a list please allow us to photocopy it)

_____

_____

14. Do you have a pacemaker or defibrillator device implant? **Yes / No When**_____

15. Do you have any metal implants / joint replacements? **Yes / No Where?**_____

16. Height_____ft. _____in. Weight_____lbs

Patient Name_____ ***Signature***_____ ***Date***____/_____***/17***