PERFORMANCE REHABILITATION

1509 West Orange Blossom Trail, Apopka, FL 32712
Phone: (407) 814-0436 Fax: (407) 814-0818

History Questionnaire

Name:		Date:
Contact Telephone Number:	E-mail Address:	
Home Address:		
Emergency Contact and Phone Number:		
Date of Injury or symptoms: ____/_____/____ mm dd yy	Description of injury or symptoms:	
Date of Surgery: ____/____/____ mm dd yy	Have you had this pain or problem before? YES NO	Is your pain on the surface or deep? Deep Surface
Medications: (include all medications)		

Medical History

Allergies	O Yes O No	Depression	O Yes O No	Multiple Sclerosis	O Yes O No
Anemia	O Yes O No	Diabetes	O Yes O No	Osteoporosis	O Yes O No
Anxiety	O Yes O No	Dizzy Spells	O Yes O No	Parkinsons	O Yes O No
Arthritis	O Yes O No	Emphysema/Bronchitis	O Yes O No	Rheumatoid Arthritis	O Yes O No
Asthma	O Yes O No	Fractures	O Yes O No	Seizures	O Yes O No
Cancer	O Yes O No	Gallbladder Problems	O Yes O No	Speech Problems	O Yes O No
Cardiac Conditions	O Yes O No	Hepatitis	O Yes O No	Strokes	O Yes O No
Cardiac Pacemaker	O Yes O No	High Blood Pressure	O Yes O No	Thyroid Disease	O Yes O No
Chemical Dependency	O Yes O No	Incontinence	O Yes O No	Tuberculosis	O Yes O No
Circulation Problems	O Yes O No	Kidney Problems	O Yes O No	Vision Problems	O Yes O No
Currently Pregnant	O Yes O No	Metal Implants	O Yes O No		

Patient Name:_____

Please list any other or surgical conditions:

Where is your pain? ☐ Neck ☐ Low Back ☐ Middle Back ☐ Shoulder Blade
☐ Shoulder ☐ Elbow ☐ Wrist ☐ Chest ☐ Hip
☐ Knee ☐ Ankle ☐ Foot ☐ Other_____

What activities are you having problems with due to this problem? (ex. Walking, reaching, sitting, standing, lifting…)

What makes your pain worse?

What makes your pain better?

Do you have any numbness or tingling? Where?

On a scale of 1 to 10, What would you rate your worst pain to be? _____/10

Mild discomfort Moderate Unbearable/Severe

1 5 10

On a scale of 1 to 10, What would you rate your pain to be now? _____/10

Mild discomfort Moderate Unbearable/Severe

1 5 10

Patient Name:_____

On a scale of 1 to 10, What would you rate your best pain to be? _____/10

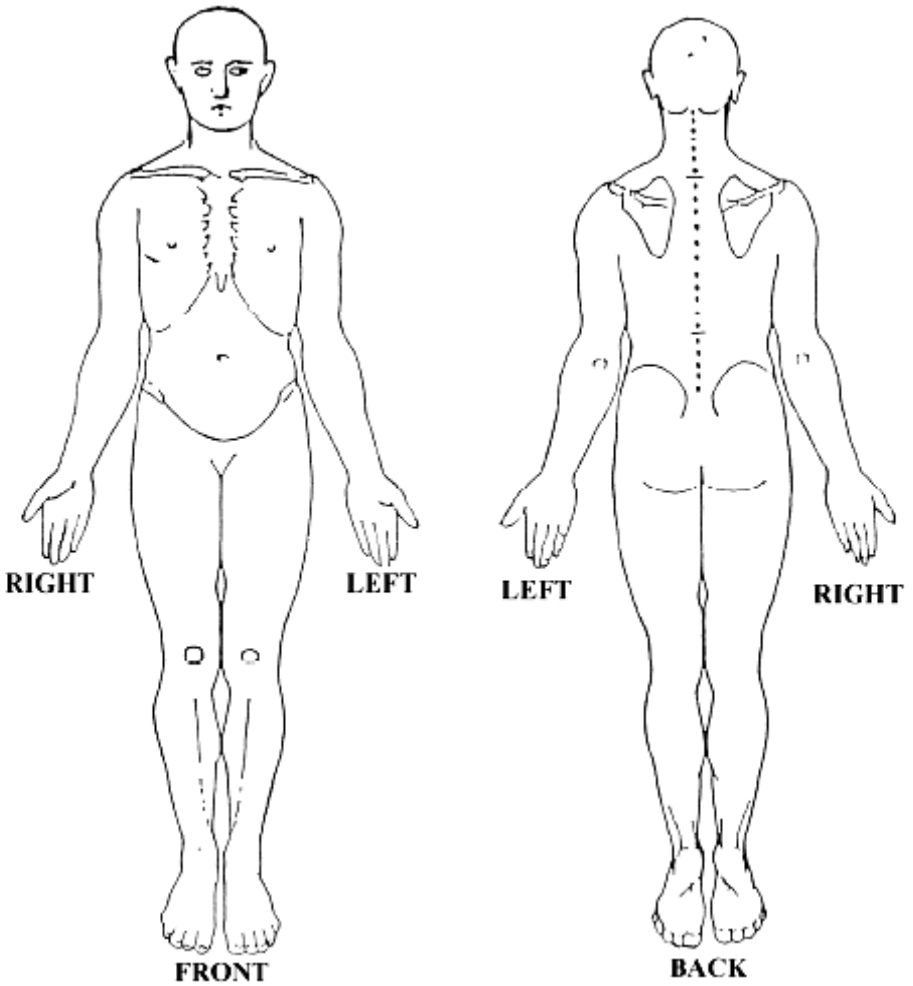
Mild discomfort Moderate Unbearable/Severe

1 5 10

Use the key below to mark the areas of the body where you are having problems:

Pain Key:

OOOO Pins and needles
XXXX Burning
//////// Stabbing
==== Dull Ache
PPPP Other – describe _____



Patient Name

Signature Date

Patient Name:_____