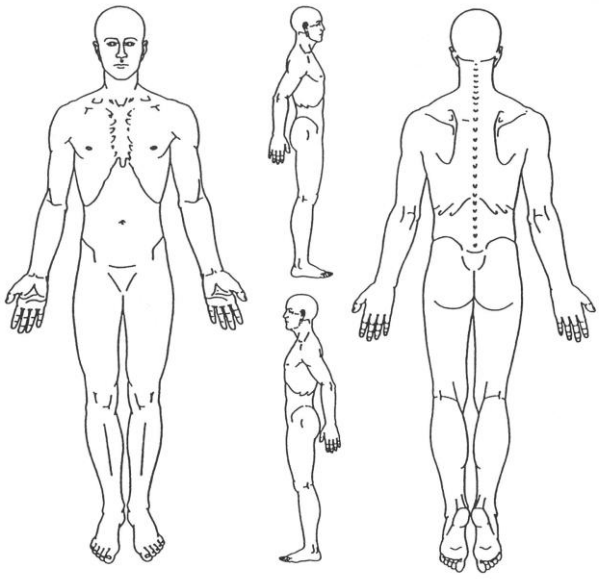
## CONDITION HISTORY

**Name** _____ **Date** _____

**PLEASE FILL IN THE APPROPRIATE SPACES (All information is confidential):**

**I. On the diagram below, indicate where you hurt.**



- Describe the onset of your symptoms.
  ☐ Sudden ☐ Gradual
- When did symptoms begin? _____
- What is the status of your symptoms?
  ☐ Getting better
  ☐ Getting worse
  ☐ Staying the same
- Is there any particular movement or activity that makes the pain worse? ☐ Yes ☐ No
  If yes, explain. _____
- What have you done to help your condition?
  _____
  Did it help? ☐ Yes ☐ No ☐ Temporarily

**II. Rate your pain as you answer the following questions.**

- How bad does it hurt on average?
  Indicate the intensity of your symptoms.
  0—1—2—3—4—5—6—7—8—9—10
- How often do you experience symptoms?
  ☐ Constantly—all the time
  ☐ Frequently—most of the time
  ☐ Intermittently—off and on
  ☐ Occasionally—once in a while
  ☐ Seldom—very little
- Describe the quality of your pain.

| | | |
|---|---|---|
| ☐ Ache | ☐ Pounding | ☐ Throbbing |
| ☐ Burning | ☐ Sharp | ☐ Tingling |
| ☐ Dull | ☐ Shooting | ☐ Tightness |
| ☐ Numb | ☐ Tender | ☐ _____ |

- Is there any time of day that it is worse?
  ☐ In the morning ☐ After work / exercise
  ☐ At night ☐ Other: _____
- What hobbies or activities of daily living are being affected by this condition? _____
  _____

1. Name any other doctors you have seen for this condition: what was done & for how long?
   _____
   Were diagnostic tests or imaging ordered (X-ray, CT, MRI, Ultrasound, etc) ☐ Yes ☐ No
   List the procedures & date: _____
2. Have you had this or a similar condition before? ☐ Yes ☐ No When? _____
3. Have you lost work days? ☐ Yes ☐ No How many? _____
4. Was the injury related to ☐ Work accident ☐ Auto accident?