

Name: _____ **General Health History** Date: ____/____/____ ☐ Verbal Consent

Presenting Complaint: ☐ Acute ☐ Subacute ☐ Chronic Onset: ☐ Insidious ☐ Traumatic Date: ____/____/____

Progression ☐ Getting Better ☐ Getting Worse ☐ Unchanged

Course:

Location:

Radiation:

Pain Intensity: ☐ Intermittent ☐ Constant Verbal pain Rating ____/10: ____ Best ____ Worse ____ Avg.

Pattern: ____ AM ____ PM ____ Progressive

Aggravating (MS):

Relieving:

Medication:

Imaging: ☐ X-Ray ☐ CT ☐ MRI Results:

Prior History ☐ Surgery ☐ Trauma ☐ MVC Details:

Prior Treatment: ☐ PT ☒ ~~SP~~ ☒ ~~MRI~~ Results:

DC MT

Occupation:

Exercise/ADLs:

Functional Deficits/ADLs:

Nutrition:

Stress/Psychological:

Sleep Pattern/Position:

Smoke: ____ packs/day Alcohol: ____ drinks/week Family History ☐ CHD ☐ CVA ☐ Cancer ☐ Diabetes ☐ Arthritis

Secondary Complaints/Notes:

WCB ONLY ☐ Self employed ☐ Employee ☐ Contract ☐ Full time ☐ Part Time ____ hrs/week

Date Started Current job: ____/____/____ Currently working: ☐ yes ☐ no If no date: ____/____/____ why?

Primary Posture: ☐ sit ☐ stand ☐ other Lifting: ____ maximum (kg) ____ frequency/hr

Signature _____ Date: ____/____/____