



**balance**  
REHABILITATION AND  
HEALTH SCIENCE, LLC

## Patient Information Record Extremity

Name: \_\_\_\_\_

MD: \_\_\_\_\_

Date: \_\_\_\_\_

Age: \_\_\_\_\_

### HISTORY OF INJURY:

1. What is your primary complaint? Left or Right? \_\_\_\_\_

2. How and when (date) did the present injury occur? \_\_\_\_\_

3. A. Precisely where did the pain start? (please indicate on diagram) **X = numbness**      **P = where pain started**

B. Where did the pain spread? (please indicate on diagram)      **T = tingling**      **R = where pain spread**

4. On a scale of 0-10 (10 being excruciating) how painful was it:

A. When it started? (please circle) 0 1 2 3 4 5 6 7 8 9 10

B. At it's best? (please circle) 0 1 2 3 4 5 6 7 8 9 10

C. At it's worst? (please circle) 0 1 2 3 4 5 6 7 8 9 10

D. How is it today? (please circle) 0 1 2 3 4 5 6 7 8 9 10

5. Did you undergo surgery? Yes \_\_\_ No \_\_\_ If yes, what was the date of surgery? \_\_\_/\_\_\_/\_\_\_

6. How long were you hospitalized? \_\_\_\_\_

7. Describe your symptoms, does it throb, \_\_\_twinge, \_\_\_burn, \_\_\_give you numbness/tingling \_\_\_?

8. What activities make your pain worse? \_\_\_\_\_

9. Can you get comfortable at night? Yes No

10. Do you have any back pain now or any history of back pain? \_\_\_\_\_

11. Do you have any problems with your bowels or bladder? \_\_\_\_\_

12. What is the effect of coughing? Worse, \_\_\_ Better, \_\_\_ Same, \_\_\_

13. How does your problem feel on rising in the morning?

Stiff \_\_\_ Sore \_\_\_ Fine \_\_\_

14. Once you start moving about, does it: Worsen \_\_\_ Ease \_\_\_ Same \_\_\_

15. What is it like at the end of the day compared to the beginning?

Worse \_\_\_ Better \_\_\_ Same \_\_\_

16. Have you ever had this problem before?

A. Is it increasing frequency? \_\_\_\_\_

B. Increasing severity? \_\_\_\_\_

C. Are your symptoms changing in character? \_\_\_\_\_

D. If yes, please describe \_\_\_\_\_

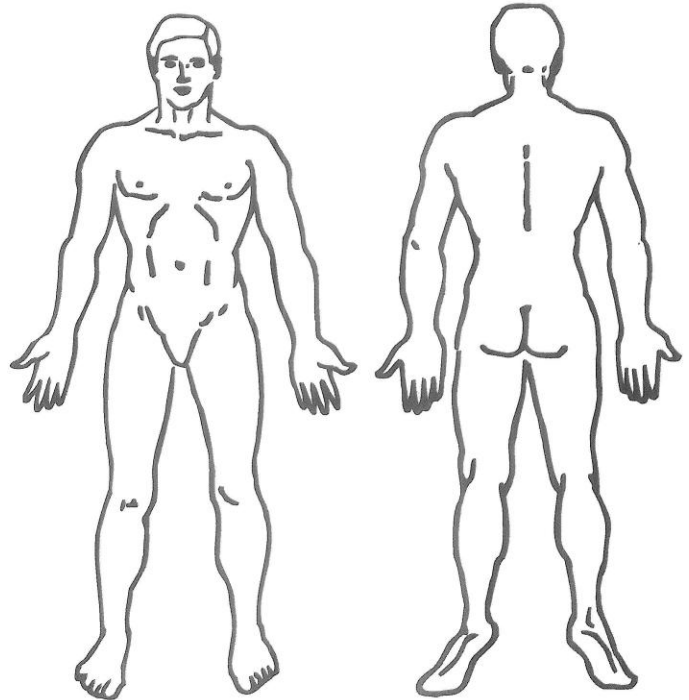
E. Can you identify what causes it? If so what? \_\_\_\_\_

\_\_\_\_\_

F. What did you do to resolve it? \_\_\_\_\_

17. Have you undergone a diagnostic medical test for this? \_\_\_\_\_

If so where? \_\_\_\_\_



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1. MEDICAL HISTORY (circle one) DO YOU HAVE OR HAVE HAD:

Yes	No	High blood pressure?	Yes	No	Impaired vision?
Yes	No	Heart disease or other cardiac condition?	Yes	No	impaired hearing?
Yes	No	Angina (chest pain)?	Yes	No	Hepatitis?
Yes	No	Shortness of breath?	Yes	No	Asthma / or Allergies?
Yes	No	Lung disease?	Yes	No	Osteoporosis?
Yes	No	Stroke?	Yes	No	Bleeding Disorders?
Yes	No	Recent weight loss/gain?	Yes	No	Sleep Disturbances?
Yes	No	Unusual joint pain and/or swelling?	Yes	No	Diabetes?
Yes	No	Dizziness and/or a History of falls?	Yes	No	Depression?
Yes	No	A history of fractures?	Yes	No	HIV/AIDS?
Yes	No	A history of cancer?	Yes	No	Arthritis?
Yes	No	Increase in frequency or intensity of headaches?	Yes	No	Seizures?
Yes	No	Are you now, or do you have any reason to believe you may be pregnant?			

2. Please rate on a scale of 0-10 how painful the following activities are; use space provided for additional comments.

Rolling over in bed _____	Ascending/descending stairs _____
Transfer to/from bed _____	Transfer to/from car _____
Bathing _____	Driving _____
Dressing _____	Walking _____
Grooming _____	Sitting _____
Carrying _____	Standing _____
Household Cleaning _____	Bending _____
Reaching level/overhead _____	Lifting _____
Meal preparation _____	Child Care _____
Using the phone _____	Other _____

3. Please list ALL medications, dosage and purpose.

\_\_\_\_\_

\_\_\_\_\_

4. Please list all surgeries and approximate dates.

\_\_\_\_\_

\_\_\_\_\_

5. Please indicate diagnostic tests for this problem.

\_\_\_\_\_

\_\_\_\_\_

6. Have you seen anyone else for your current problems? If so, please list.

\_\_\_\_\_

\_\_\_\_\_

**Consent to Medical Treatment**

I, \_\_\_\_\_, voluntarily consent to diagnostic procedures and related medical treatment as recommended by my physical therapist and their designees, and acknowledge that no guarantees have been or can be made as to the result of such treatments. This questionnaire is considered a part of your confidential medical record.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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