CL178

NAME: ______________________________
BIRTHDATE: __________________________
DATE: _______________________________

HISTORY QUESTIONNAIRE

1. Reason for visit today: ____

2. How long has problem/pain been going on: ________________________________

3. Is this an injury? Yes / No
   - Where it happened (home, school, work, etc.) ______________________________
   - Type of activity that contributed to injury (sports, driving, housework, etc.)________________
   - How it happened: ____
   - Is injury work comp or motor vehicle? (Circle one if applicable.)

4. Describe the type of pain/problem when it occurred: ___________________________
   ____

5. What do you do to decrease pain/problem: _________________________________
   ____

6. What do you do to increase pain/problem: _________________________________
   ____

7. Have you sought medical advice for pain/problem? If so, what is recommended: ______________
   ____

8. Have you had same/similar problem: ______________________________________

9. On a scale of 1-10 with 10 being the absolute worst, rate your pain: ___________________

10. Have you had any joint injections before? If yes, when: __________________________

LIST ALL MEDICATIONS, VITAMINS AND HERBS YOU TAKE: ___________________________
____

LIST ALL PRIOR SURGERY: ____
____

LIST ALL MEDICAL PROBLEMS YOU HAVE: _______________________________________
____

LIST ALL ALLERGIES: ____

LIST ALL KNOWN MEDICAL PROBLEMS/DEATH OF PARENTS/SIBLINGS: ____________________
____

Occupation: ______________________________

Do you smoke? Yes ___ No ____ If yes, how much? ____________________________________

Do you drink alcohol? Yes ____ No ___ If yes, how much and how often? _____________________

Hand Dominance: Right ____ Left ____