**MEDICAL HISTORY**

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

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

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_ Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status (circle one): Single Married Divorced Widowed Separated

Rate pain level (0 – 10) at its:

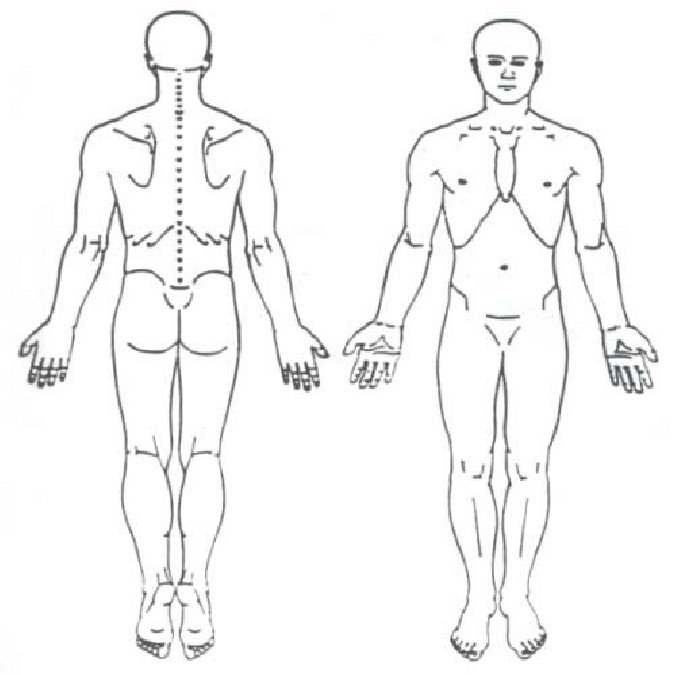
Current\_\_\_\_\_\_ Best \_\_\_\_\_\_ Worst\_\_\_\_\_\_

Date of onset of pain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Improving/worsening/unchanging

Describe how your pain began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please mark location of pain



How would you describe your pain?

* Burning
* Cramping
* Pins and needles
* Sharp
* Numbness
* Shooting
* Dull, aching
* Throbbing
* Electric- like
* Pressure
* Other \_\_\_\_\_\_\_

How do the following affect your pain?

|  |  |  |  |
| --- | --- | --- | --- |
|  | Better | Worse | No affect |
| Lying down |  |  |  |
| Standing |  |  |  |
| Sitting |  |  |  |
| Walking |  |  |  |
| Exercise |  |  |  |
| Morning |  |  |  |
| Evening |  |  |  |
| When still |  |  |  |
| On the move |  |  |  |

Have you had any changes to your bowel or bladder function since start of pain? Yes \_\_\_\_\_ No \_\_\_\_\_\_

Have you had physical or occupational therapy for your pain this year? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

OVER

How does your pain interfere with the following activities?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Activity** | **Does not interfere** | **Occasionally interferes** | **Often interferes** | **Completely interferes** |
| Going to work |  |  |  |  |
| Household chores |  |  |  |  |
| Stairs |  |  |  |  |
| Recreational activity |  |  |  |  |
| Driving |  |  |  |  |
| Sleeping |  |  |  |  |
| Bathing |  |  |  |  |
| Getting dressed |  |  |  |  |

Have you had any falls in the past year? No\_\_\_ Yes\_\_\_ If yes, how many? \_\_\_

Do you have history of (circle all that apply): Head trauma Whiplash Temporal Mandibular Joint (TMJ) dysfunction

**Personal Medical History** (check if *yes*)

* Cancer
* Arthritis
* High blood pressure
* Congestive heart failure
* Pulmonary disease
* Heart attack
* Stroke
* Diabetes
* Glaucoma
* Macular degeneration
* Depression
* Autoimmune disease\_\_\_\_\_\_\_\_\_

**Past Surgeries:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications (list or provide a copy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**At Peak, we are committed to helping you achieve whole body wellness. The following questions pertain to your general health and level of well-being:**

How many days per week (avg) do you engage in moderate to vigorous physical activity (brisk walk)? \_\_\_\_\_\_ days

How many minutes (avg) do you engage in physical activity at this level? \_\_\_\_\_\_\_ minutes

How many days a week do you perform strengthening exercises (bodyweight or resistance training)? \_\_\_\_\_\_ days

**How much of the time during the past 4 weeks…**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | All of the time | Most of the time | A good bit of the time | Some of the time | A little of the time | None of the time |
| Did you eat a diet with 5 or more servings of fruit and vegetables (in a day) |  |  |  |  |  |  |
| Have you felt stressed or anxious |  |  |  |  |  |  |
| Did you awake feeling rested |  |  |  |  |  |  |
| Has your physical or emotional status interfered with your social activities |  |  |  |  |  |  |
| Used tobacco products |  |  |  |  |  |  |
| Consumed alcohol |  |  |  |  |  |  |

I am interested in achieving optimal wellness to help prevent future injuries and illnesses. Please provide me with more information on (check all that apply)…

* Nutrition
* Stress Management
* Tobacco or Alcohol cessation
* Quality Sleep
* Physical Fitness
* Emotional Well-being