STARACE TOTAL BALANCE
PHYSICAL THERAPY P.A.

Medical History

INJURY DETAILS

Type of Injury: _____ Date of Onset: _____

How did the injury occur? _____

List any medications you are presently taking (if any): _____

Have you had x-rays taken for this injury? ☐ Yes ☐ No

PAIN DESCRIPTION

Which of the following best describes your pain? (check one) ☐ Sharp ☐ Dull ☐ Aching ☐ Shooting

Which of the following best describes the frequency of your pain? (check one) ☐ Constant ☐ Intermittent ☐ Occasional

What makes your pain feel worse? (check all that apply) ☐ Lifting ☐ Leaning ☐ Dressing ☐ Climbing ☐ Sitting ☐ Walking ☐ Standing ☐ Reaching ☐ Driving ☐ Bending ☐ Stooping ☐ Laying Down

What makes your pain feel better? _____

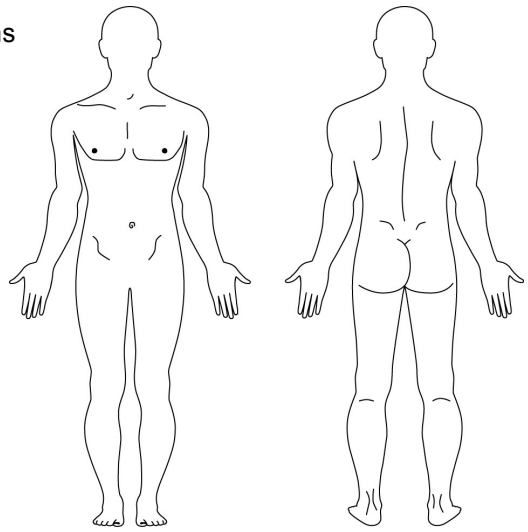
Please rate the level of pain you have experienced over the past 30 days:	NO PAIN 0	1	2	3	4	MODERATE PAIN 5	6	7	8	9	WORST PAIN 10
What number on the pain scale best describes your pain **right now**?	○	○	○	○	○	○	○	○	○	○	○
What number on the pain scale describes your **worst pain** over the past 30 days?	○	○	○	○	○	○	○	○	○	○	○
What number on the pain scale describes your **least pain** over the past 30 days?	○	○	○	○	○	○	○	○	○	○	○

SYMPTOM DIAGRAM

Using the diagram at right, please indicate the location and type of symptoms you are experiencing.

(Use the symbols from the diagram key to indicate the location and type of symptom on the image.)

DIAGRAM KEY	
SYMBOL	SYMPTOM
X	pain
. . . . .	numbness
_ _ _ _	tingling



GENERAL MEDICAL HISTORY

Do you have a history of cancer?..... ☐ Yes ☐ No

Do you have a pacemaker? ..... ☐ Yes ☐ No

Do you have hypertension?..... ☐ Yes ☐ No

Do you have bowel/bladder problems?..... ☐ Yes ☐ No

Are you diabetic?..... ☐ Yes ☐ No

Are you pregnant? ..... ☐ Yes ☐ No

Please list any other relevant past medical or orthopedic history: _____