

## MEDICAL HISTORY/PAIN CHART AND ADL SCREEN

PATIENT: \_\_\_\_\_ AGE: \_\_\_\_\_

Diagnosis as stated to you by your physician: \_\_\_\_\_ Date of onset? \_\_\_\_\_

How did this injury/exacerbation occur? \_\_\_\_\_

Have you been hospitalized for the present condition?  YES  NO If Yes, date: \_\_\_\_\_

Have you had surgery for the present condition?  YES  NO If Yes, date: \_\_\_\_\_

Have you received previous treatment for this condition?  YES  NO If Yes, date: \_\_\_\_\_

If yes, please summarize: \_\_\_\_\_

Are you currently receiving or have you received in the last 30 days any other home health, medical or chiropractic services rendered to you by any other agency, organization or individual?  YES  NO If yes, please summarize: \_\_\_\_\_

Are you on any medications?  YES  NO Please list (you may use reverse side)

Have you ever had any of the following?  EMG  CAT  SCAN  MYELOGRAM  MRI  XRAY

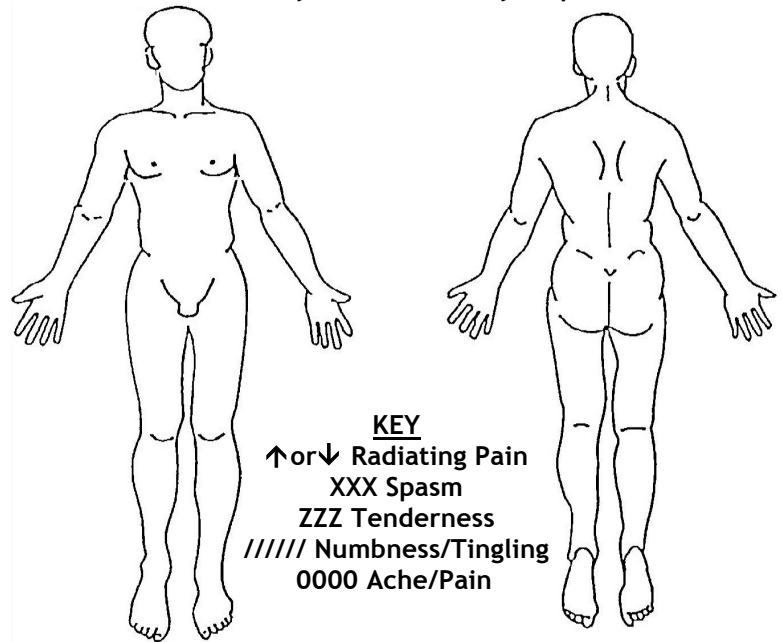
Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Dizzy Spells	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fainting Spells	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Epilepsy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pregnancy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Osteoperosis/Osteopenia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Back injury	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bleeding disorder	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fracture	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pacemaker	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Metalology (implants)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Respiratory problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hepatitis A,B,C	<input type="checkbox"/> YES	<input type="checkbox"/> NO
MRSA	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HIV/AIDS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO
High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bowel/bladder problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sudden weight loss	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Allergies	<input type="checkbox"/> YES	<input type="checkbox"/> NO
List:		

Please circle all that may apply. My pain is worse:  
In the morning/during the day/at night/constantly/  
with activity/during rest.

On a scale of 0 to 10,  
0 being no pain and 10 being unbearable pain requiring hospitalization,  
rate your pain at its best \_\_\_\_\_ and worst \_\_\_\_\_.

Using the key provided, draw the symbol representing your pain  
over the area of the body as it relates to your present condition.



As it relates to your current problem, are you unable to or have difficulty with performing any of the following activities? Do you have pain associated with or have you changed your method of performing any of the following tasks? **Check all that apply?**

- |   |  |                                   |                                    |                                   |
|---|--|-----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Getting in/out of bed    | <input type="checkbox"/> Personal hygiene activities | <input type="checkbox"/> Eating   | <input type="checkbox"/> Shaving   | <input type="checkbox"/> Cleaning |
| <input type="checkbox"/> Getting in/out of car    | <input type="checkbox"/> Bathing/shower              | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Lifting   | <input type="checkbox"/> Writing  |
| <input type="checkbox"/> Getting in/out of chair  | <input type="checkbox"/> Brushing teeth              | <input type="checkbox"/> Sitting  | <input type="checkbox"/> Cooking   | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Walking up/down stairs   | <input type="checkbox"/> Dressing                    | <input type="checkbox"/> Standing | <input type="checkbox"/> Laundry   | <input type="checkbox"/> Driving  |
| <input type="checkbox"/> Getting in/out of shower | <input type="checkbox"/> Work activities             | <input type="checkbox"/> Walking  | <input type="checkbox"/> Vacuuming |                                   |
| <input type="checkbox"/> Other _____              |  |                                   |                                    |                                   |

✍ Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_