General History of Present Illness

Name:_______________________________ Today's Date: _______

1 Date of onset: ________________

2 If No Incident

( ) Woke up with Pain
( ) Pain woke them up
( ) Slow Onset
( ) No Reason (History of Pain)

3 Activities you have pain with:

( ) Sports: ( ) Golf ( ) Football ( ) Softball ( ) Other: ______
( ) Functional Activity: ( ) Gardening ( ) Cutting grass
( ) Shoveling ( ) Weed Wacking ( ) Other: _________
( ) Activities of Daily Living: ( ) Vacuuming
( ) Laundry ( ) Cleaning
( ) Cooking ( ) Other: ______________________

4 Trauma Yes / No

( ) Slip and Fall
( ) Slip but didn't Fall
( ) Fall down steps or off curb
( ) Motor vehicle accident
( ) Hit by a car as a pedestrian
( ) Other: ______________________

5 Since the onset, the pain interferes with:

( ) Sitting After ___________ (Minutes / Hours)
( ) Standing After ___________ (Minutes / Hours)
( ) Walking After ___________ (Minutes / Hours)
( ) Activities of daily living: ( ) Dressing ( ) Bathing or Shower ( ) Cleaning the house
( ) Sleep: ( ) Getting to sleep ( ) Wake up because of pain
( ) Recreational Activities: ( ) Golf ( ) Basketball ( ) Softball ( )Gymnastics ( ) Other:_______

6 History of pain:

( ) Intermittent for ___ years ( ) Constant for ___ years ( ) Never had this before

7 Problems with any of the folowing?

( ) Sense of smell ( ) Blurred Vision ( ) Speech ( ) Memory
( ) Sense of taste ( ) Swallowing ( ) Balance
( ) Hearing ( )Facial weakness ( ) Numbness / pain in face

8 Accidents/Injuries/Falls: ______________________________________

____

9 Conditions / Illnesses: ______________________________________

____

10 Surgeries: ______________________________________

____

11 Fractures: ______________________________________

____

12 Hospitilizations: ______________________________________

Recent Films (X-Ray/MRI) ______________________________________

13 Pregnancy(ies): ______________________________________

Are you or could you be currently pregnant? ______________________________

14 Allergies: ______________________________________

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15 Medications: ______________________________________

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16 Supplements: ______________________________________

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17 Water Intake: ______________________________________