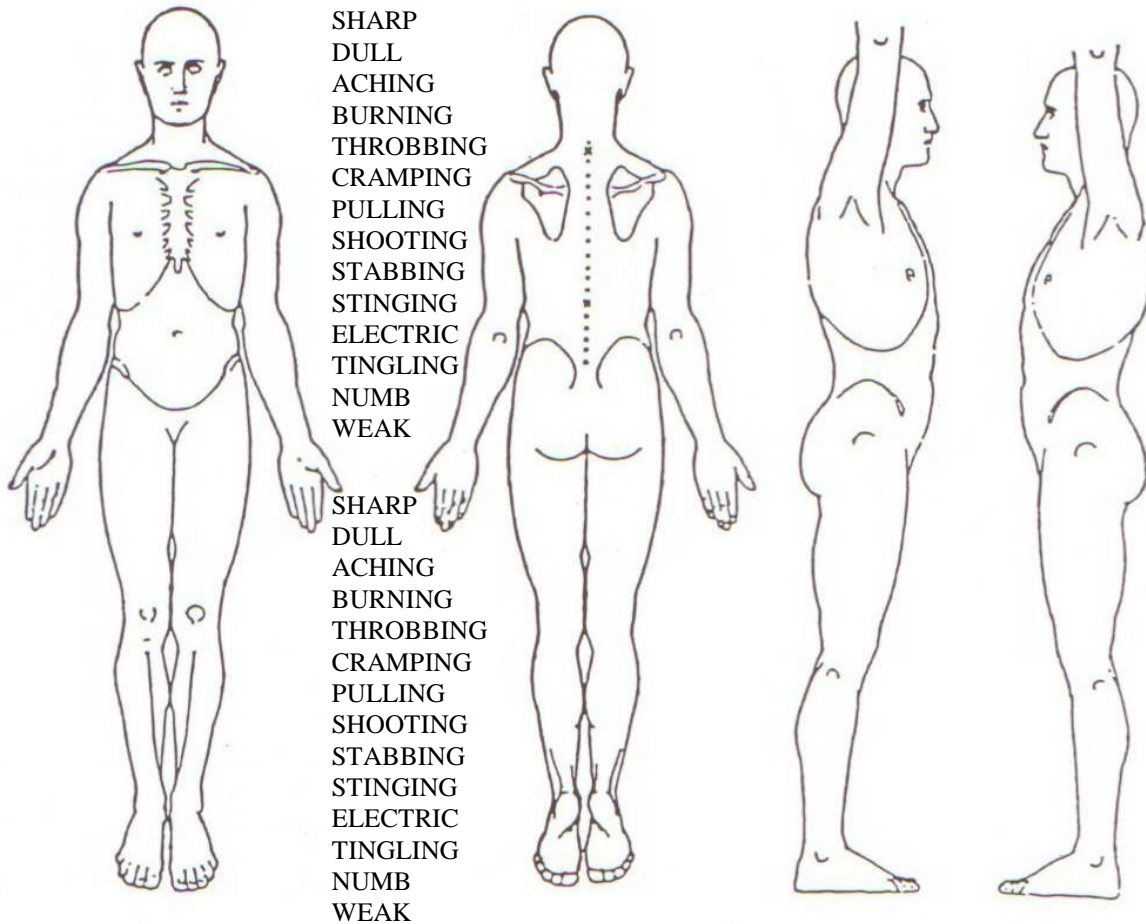


Please shade the areas of the diagrams below that correspond to your pain and circle any words that best describe your pain. You may draw arrows from the words to the areas they describe.



Pain Range (Best/Usual/Worst): 1 2 3 4 5 6 7 8 9 10
 (use a slash to mark each)

Frequency/Duration: _____

Over time, the problem is better worse unchanged waxes and wanes tends to flare-up

Any problems holding your urine? Yes No Any problems holding your stool? Yes No

Worse	Better	No Diff	Action	What brings the pain on: _____
()	()	()	rest	_____
()	()	()	activity in general	_____
()	()	()	sitting	_____
()	()	()	driving	_____
()	()	()	standing	Associated symptoms: _____
()	()	()	walking	_____
()	()	()	reaching	_____
()	()	()	bending	_____
()	()	()	twisting	_____
()	()	()	coughing/sneezing	What helps: _____
()	()	()	straining at stools	_____

INVESTIGATIONS PERFORMED:

Plain X-rays MRI CT

EMG/NCS Blood Tests Other Tests

PREVIOUS TREATMENT:

RESULTS

Surgeries _____

Injections (epidurals, trigger point, etc.) _____

P.T. (Ultrasound/Estim) _____

P.T. (manual therapy) _____

P.T. (exercises) _____

Osteopathic/Chiropractic _____

Massage _____

Acupuncture _____

Other (Energy Healing, MindBody Tx, etc.) _____

PAST MEDICAL HISTORY: (Conditions requiring medication and any serious illnesses)

SURGERIES: (other than above) _____

FAMILY HISTORY: (diabetes, heart disease, stroke, high blood pressure, cancer, arthritis, other)

CURRENT MEDICATIONS:

currently take dosage times per day for which medical problem

PRIOR MEDICATIONS :

results/side effects

MEDICATION ALLERGIES: _____

JOHN GIUSTO, MD, PLLC

PHYSICAL MEDICINE & REHABILITATION

Office: (919) 929-7990 • Fax: (919) 929-7991

PATIENT:

Date:

SLEEP: Hours/night ____ Trouble falling asleep? Yes No Trouble staying asleep? Yes No
Wake up because of pain? Yes No Feel rested? Yes No Sleep Aids _____

Concerns: _____

DIET: red meat poultry fish eggs dairy Junk foods _____

Concerns: _____

COUNSELING: (any counseling, psychological, or psychiatric treatment for any reason) Yes No

Any history of childhood physical/psychological trauma or abuse? Yes No _____

SOCIAL HISTORY: Single/Married/Widowed/Divorced Children (ages): _____

Family/Financial stress: _____

Other stress: _____

Physical Activity/Exercise: _____

Hobbies/Interests: _____

Spirituality: _____

WORK STATUS: Full duty/Modified duty/off work/unemployed Last Worked: _____

Job Description: _____

Dissatisfaction/Conflicts: _____

HABITS: Tobacco: ____ packs/day x ____ yrs Alcohol beer wine liquor: ____ drinks/day (week)

Coffee/tea: ____ cups/day Other: _____

SYSTEMS REVIEW: (Circle any current problems or mark Neg.)

- Constitutional: Neg. Fever, chills, night sweats, fatigue, weight loss or weight gain.
- Cardiovascular: Neg. Chest pains, palpitations, heart murmur, or circulatory problems.
- Respiratory: Neg. Cough, shortness of breath, or wheezing.
- GI: Neg. Nausea, vomiting, constipation, diarrhea, ulcers, or dark stool.
- GU: Neg. Burning urination, blood in urine, dribbling, or poor stream.
- Musculoskeletal: Neg. Other significant joint or muscle pains.
- Skin: Neg. Rashes, lumps, sores, or itching.
- Neurological: Neg. Headaches, dizziness, loss of balance, or seizures.
- Psychological: Neg. History of anxiety, depression, psychosis, or suicidal thoughts.
- Endocrine: Neg. Diabetes, thyroid problems, or hormonal disorders.
- Hematologic: Neg. Anemia, easy bruising, blood disorders, or history of transfusion.
- ENT: Neg. Trouble swallowing, ears ringing, sinus, throat, or mouth infections.
- Eyes: Neg. Double or blurry vision.
- Other: Neg. Pregnant (any chance), history of chemical exposures.