55 Vilcom Center Dr, Suite 110 ∞ (919) 929 - 7990

Patient History

Date_____

Name _____ Date of Birth: _____

1. Describe the current problem that brought you here?_____
_____

2. When did your problem first begin? ___ months ago or ___ years ago

3. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify date _____
_____

4. Since that time is it: ___staying the same ____ getting worse ____getting better
Why or how?_____

5. If pain is present, rate pain on a 0-10 scale (0 being no pain and 10 being emergency room) _____

6. Describe previous treatment/exercises_____
_____

7. Activities/events that cause or aggravate your symptoms. Check all that apply:

___ Sitting greater than _____ minutes
___ Walking greater than ___ minutes
___ Standing greater than ___ minutes
___ Light activity (e.g. light housework)
___ Changing positions (e.g. sit to stand)
___ Vigorous activity/exercise (e.g. run/weight lift/jump)
___ Sexual activity
___ Cough/sneeze/straining
___ Laughing/yelling
___ Lifting/bending
___ With triggers -running water/key in door, unzipping pants, etc.
___ With nervousness/anxiety
___ Other, please list _____

8. What relieves your symptoms?_____

9. How has your lifestyle/quality of life been altered/changed because of this problem?
Social activities (exclude physical activities), specify_____
Diet /Fluid intake, specify _____
Physical activity, specify _____
Work, specify _____

10. Rate the severity of this problem from 0 -10 (0 being no problem, 10 being the worst) ___

11. What are your treatment goals/concerns?_____

_____

Since the onset of your current symptoms have you had:

Y/N	**Fever/Chills**	**Y/N**	**Malaise (Unexplained tiredness)**
Y/N	**Unexplained weight change**	**Y/N**	**Unexplained muscle weakness**
Y/N	**Dizziness or fainting**	**Y/N**	**Night pain/sweats**
Y/N	**Change in bowel or bladder functions**	**Y/N**	**Numbness / Tingling**

General Health: **Excellent Good Average Fair Poor**

Work hours/week_____ **On disability or leave?**____ **Activity Restrictions?** _____

Mental Health: **Current level of stress High**_____ **Med**____ **Low**_ __

Activity/Exercise: **None 1-2 days/week 3-4 days/week 5+ days/week**

Describe _____

Have you ever had any of the following conditions or diagnoses? Circle all that apply:

Cancer	**Stroke**	**Emphysema/chronic**
Heart problems	**Epilepsy/seizures**	**Asthma**
High Blood Pressure	**Multiple sclerosis**	**Allergies-list below**
Anemia	**Osteoporosis**	**Latex sensitivity**
Low back pain	**Chronic Fatigue Syndrome**	**Headaches**
Sacroiliac/Tailbone pain	**Fibromyalgia**	**Diabetes**
Smoking history	**Arthritic conditions**	**Hypo/Hyperthyroid**
Childhood bladder problems	**Stress fracture**	**Irritable Bowel Syndrome**
Depression	**Rheumatoid Arthritis**	**TMJ/ neck pain**
Anorexia/bulimia	**Physical or Sexual abuse**	**Pelvic pain**
Vision/eye problems	**Hearing loss/problems**	**Numbness/tingling**

Other/Describe_____

Surgical /Procedure History

Y/N	**Surgery for your back/spine**	**Y/N**	**Surgery for your bladder/prostate**
Y/N	**Surgery for your female organs**	**Y/N**	**Surgery for your abdominal organs**

Other/describe_____

Ob/Gyn History

Y/N	**Childbirth vaginal deliveries #**__	**Y/N**	**Vaginal dryness**
Y/N	**Episiotomy #**_____	**Y/N**	**Painful periods**
Y/N	**C-Section #**__	**Y/N**	**Menopause - when?** _____
Y/N	**Difficult childbirth #**_____	**Y/N**	**Painful vaginal penetration**
Y/N	**Prolapse or organ falling out**	**Y/N**	**Pelvic pain**

Medications - pills, injection, patch	**Start date**	**Reason for taking**

Over the counter -vitamins etc	**Start date**	**Reason for taking**