MADDEN PHYSICAL THERAPY

MEDICAL HISTORY

Patient Name: ________________________________ **Date:** ____________

Medical History: Are you currently experiencing or have you had any of the following:

High Blood Pressure	Y N	Heart Disease	Y N	Numbness	Y N
Bowel/Bladder Problems	Y N	Pacemaker	Y N	Cancer	Y N
Shortness of Breath	Y N	Weakness	Y N	Pregnant	Y N
Female Problems	Y N	Diabetes	Y N	Dizziness	Y N
Night Pain	Y N	Fatigue	Y N	Osteoporosis	Y N
Irregular Heart Rate	Y N	Headaches	Y N	Stroke	Y N

Surgeries? Y N (List) ________________________________

How would you rate your general health? (circle one) Poor Fair Good Excellent

In the past 3 months, have you experienced any significant changes in health (physical or mental) such as unexplained weight loss, depression, nausea, etc? (List)________________________________

List other medical problems: ________________________________

Currently:

What is your current complaint? ____________________ When did it start? ____________

Due to an injury? Y N (Explain) ____________________ Illness? ____________

Did the symptoms begin: Suddenly or Gradually Previous problems in this area? Y N

Previous therapy for this condition? Y N What effect? ____________________

Have you had chiropractic or any other treatment for condition? Y N

Are you getting: Better Same Worse Are you better with rest? Y N

Does activity make you worse? Y N Which activities? ____________________

Are you worse in the: Morning Afternoon Evening Is your pain: Continuous Occasional

Does your pain radiate? Y N Where? ____________________

What reduces your pain? ____________________

What can't you do because of your symptoms? ____________________

Recent tests: X-ray CT MRI EMG Myelogram Other ____________________

Results: ____________________

What did the Doctor tell you is your diagnosis? ____________________

Did the physician put you on any restrictions? Y N List: ____________________

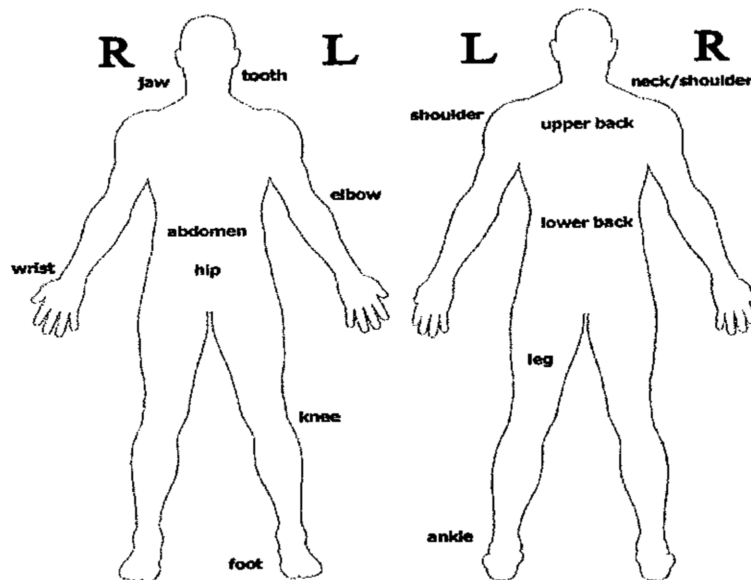
Are you currently employed? Y N What are your job tasks? ____________________

Based upon a 0 to 10 scale (0 is none and 10 is severe), what is your pain:

Right now: _______ Highest pain in past 24 hours: ________ Lowest pain in past 24 hours: ________

PLEASE COLOR YOUR AREA OF PAIN ON THE BODY DIAGRAM BELOW

FRONT BACK



MADDEN PHYSICAL THERAPY

<u>Shoulder, Elbow, Wrist, Hand</u>

Upper Extremity Questionnaire

Patient Name: ______________________ D.O.B.__________ Date: __________

ACTIVITIES Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.	No Difficulty	Mild Difficulty	Moderate Difficulty	Severe Difficulty	Unable
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors)	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Use a knife to cut food.	1	2	3	4	5
5. Wash your back.	1	2	3	4	5
6. Recreation activities in which you take some force or impact through your arm, shoulder, or hand. (e.g., golf, hammering, tennis, etc.)	1	2	3	4	5
7. During the past week, how much difficulty have you had sleeping because of pain in your arm, shoulder or hand?	1	2	3	4	5
8. During the past week, to *what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	Not at All 1	Slightly Limited 2	Moderately Limited 3	Quite a bit 4	Extremely Limited 5
9. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	Not at All 1	Slightly Limited 2	Moderately Limited 3	Quite a bit 4	Extremely Limited 5
10. Rate the severity of your arm, shoulder or hand pain.	None 1	Mild 2	Moderate 3	Severe 4	Extreme 5
11. Rate the severity of tingling (pins and needles) in your arm, shoulder or hand.	None 1	Mild 2	Moderate 3	Severe 4	Extreme 5