ROI
REHABILITATION
OPTIONS of ISSAQUAH

Name:___________________________

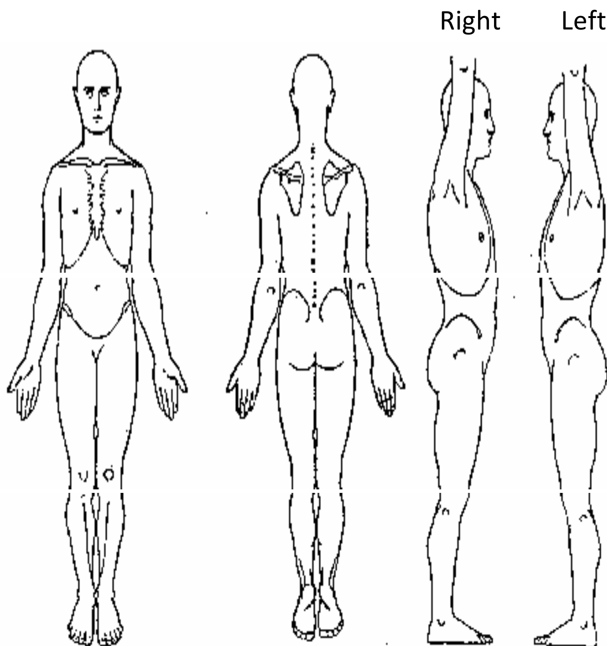
Date:

History of Present Condition

1. What are your symptoms?
   ____
   ____
   ____
2. When did your symptoms begin?
   (Indicate a specific date if possible)__________

Locate areas of pain or abnormal sensation on the body chart below (Shade where appropriate)

Right Left



3. Was the onset of this episode ***gradual*** or ***sudden***? (Circle ONE)
4. Which of the following best describes how your injury occurred?
   - ☐ Lifting
   - ☐ Car Accident (MVA)
   - ☐ Incident at Work
   - ☐ Fall
   - ☐ Overuse
   - ☐ Trauma
   - ☐ Degenerative Process
   - ☐ During recreation/Sports
   - ☐ Throwing
   - ☐ Unknown
   - ☐ Other______________________________
     ____

5. Since onset are your symptoms getting:
   ☐ Better ☐ Worse ☐ Not Changing
6. Have you had similar symptoms in the past?
   ☐YES ☐ NO
   More than 1 episode? ☐Yes ☐No
7. Nature of pain/symptoms (check all that apply)
   ☐ sharp ☐ aching ☐ occasional
   ☐ dull ☐ periodic ☐ other____________
   ☐ throbbing ☐ constant
8. As the day progresses, do your symptoms:
   ☐ increase ☐ decrease ☐ stay the same
9. Does the pain wake you at night? ☐ No ☐ Yes
   If "yes" is it present:
   ☐ while lying still
   ☐ only when changing positions
   ☐ both
10. Do you have pain/stiffness upon getting out of bed in the morning? ☐ Yes ☐ No
11. In what position do you sleep (check all that apply)
    ☐ right side ☐ left Side
    ☐ back ☐ chair/recliner
    ☐ stomach ☐ Back/side/stomach
    ☐ other________________________________
12. Since the onset of your symptoms have you had
    ☐ difficulty with control of bowel or bladder Function
    ☐ fever/chills
    ☐ numbness of ________________________
    ☐ dizziness or fainting attacks
    ☐ weakness
    ☐ unexplained weight change
    ☐ night pain/sweats
    ☐ malaise
    ☐ problems with vision or hearing
13. What relieves your symptoms?
    (check all that apply)
    ☐ sitting ☐ standing ☐ massage
    ☐ heat ☐ exercise ☐ medication
    ☐ cold ☐ walking ☐ stretching
    ☐ rest ☐ lying down ☐ wearing a splint
    ☐ other_____________________________
    ☐ Nothing relieves my symptoms

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Date:

14. What aggravates your symptoms?
    (Check all that apply)
    ☐ sitting
    ☐ standing
    ☐ squatting
    ☐ coughing/sneezing
    ☐ taking a deep breath
    ☐ going to/rising from sitting
    ☐ lying down
    ☐ walking
    ☐ up/down stairs
    ☐ reaching overhead
    ☐ reaching in front of body
    ☐ reaching behind back
    ☐ reaching across body
    ☐ looking up overhead
    ☐ sustained bending
    ☐ stress
    ☐ recreation/sports including________________
    ☐ other___________________________________

Past Medical History

Do you now or have you ever had: (check if "yes")

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Thyroid problems
❑ Depression
❑ Cancer (type) ________________
❑ Multiple Sclerosis
❑ Arthritis/Rheumatoid Arthritis
❑ Head Injury
❑ Heart problems
❑ Stomach problems
❑ Lung Problems
❑ Parkinson's disease
❑ Infectious disease
❑ Allergies
❑ Asthma
❑ Circulation problems
❑ Stroke/Vascular
☐ Osteoporosis
❑ Epilepsy (seizures)
❑ Broken bones
❑ Other______________

Please List any recent/relevant past surgeries related to your current problem:

Surgery   Date

____

____

____

FOR

Family History

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following?

❑ Diabetes
❑ High blood pressure
❑ Stroke
❑ Thyroid problems
❑ Psychological Condition
❑ Cancer (type) _________________
❑ Osteoporosis
❑ Arthritis
❑ Other________________________

Medications

Please list any prescription medications you are currently taking (pain pills, injections/patches, etc):

____

____

____

____

Prescribing MD:__________________________

Phone #__________________________________

Are you currently taking any of the following over the counter medication?

☐ aspirin
☐ Tylenol
☐ antihistamines
☐ Advil/Motrin/Ibuprofen
☐ corticosteroids
☐ vitamins/mineral supplements
☐ other____________________________

____

Do you have any allergies to medication? Yes or No

If yes please list:

____

____

____

____

____

Name:___________________________

Date:

To provide the best medical care, and for the safety of your children, and privacy of other patients, ROI does not permit children to accompany parents to medical or physical therapy appointments. If you do not have available childcare we would be happy to reschedule your appointment.

Thanks,

ROI Staff

____

Patient Signature

____

Date