Health History Form

Name: _____ Age: _____ Date: _____

1. Are you experiencing any tingling and/or numbness? If so, where?

   _____

2. List your hobbies/leisure activities:

   _____

3. Please circle which activities in question #2 you have stopped since your injury.
4. What is your occupation? Describe the physical requirements:

   _____

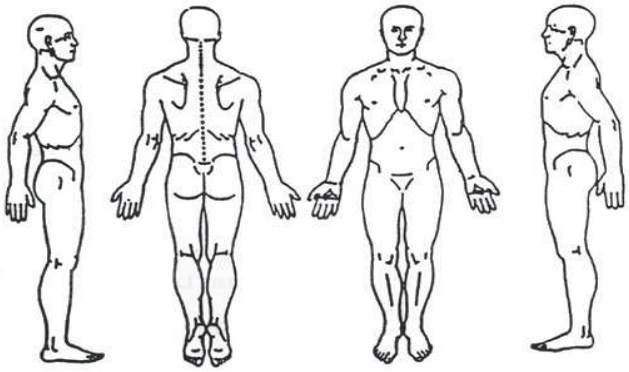
5. Do you have pain with certain activities/movements? Please explain.

   _____

6. List any medications you are currently taking:

   _____

7. Indicate where you are having symptoms and severity of pain experienced:



None *Unbearable*

0 1 2 3 4 5 6 7 8 9 10

8. Please complete each statement that pertains to <u>your injury</u>, using your best judgment:

   <u>ALL:</u> I am currently able to complete tasks at work for _____ minutes at a time.

   <u>Lower Body</u>: I am currently able to stand for _____ minutes at a time.

   I am currently able to walk for _____ minutes at a time.

   I am currently able to climb _____ stairs at a time.

   I am currently able to sit for _____ minutes at a time.

   <u>Lower Body, Back, & Neck:</u> I am currently able to perform _____ % of a full squat (90°).

   <u>Upper Body, Back, & Neck:</u> I am currently able to reach as high as my chest, shoulder, eye, overhead. (Circle)

   <u>Upper Body, Back, & Neck:</u> I am currently able to lift _____ pounds.