# History of Present Illness

**Why are you here today?** (Select one)
- [ ] an injury at work
- [ ] an injury during sports
- [ ] an injury during a MYA
- [ ] pain
- [ ] a surgery
- [ ] weakness

Additional Comments:

**On what date did this occur?**

**Do you have pain?**
- [ ] Yes
- [ ] No

**Which side?** (Select all that apply)
- [ ] left
- [ ] right

**Where is this pain located?** (Select all that apply)
- [ ] neck
- [ ] upper back
- [ ] shoulder
- [ ] arm
- [ ] hand
- [ ] mid back
- [ ] hip
- [ ] buttock
- [ ] leg
- [ ] ankle
- [ ] foot
- [ ] knee
- [ ] lower back

**What makes this pain worse?** (Select all that apply)
- [ ] running
- [ ] stair climbing
- [ ] kneeling
- [ ] jumping
- [ ] twisting
- [ ] pivoting
- [ ] squatting
- [ ] prolonged sitting
- [ ] standing
- [ ] bending
- [ ] sitting
- [ ] driving
- [ ] walking
- [ ] overhead reaching
- [ ] cough/sneeze/holding breath
- [ ] sleeping

**What makes this pain better?** (Select all that apply)
- [ ] nothing
- [ ] rest
- [ ] pain medication
- [ ] ice
- [ ] heat
- [ ] bracing
- [ ] cane/walker
- [ ] immobilization
- [ ] elevation
- [ ] cortisone injections
- [ ] sitting
- [ ] standing
- [ ] walking
- [ ] overhead reaching

**How would you describe this pain?** (Select all that apply)
- [ ] dull
- [ ] sharp
- [ ] aching
- [ ] throbbing
- [ ] shooting
- [ ] constant
- [ ] intermittent

**Do you have other symptoms?**
- [ ] Yes
- [ ] No

**What are the symptoms?** (Select all that apply)
- [ ] swelling
- [ ] instability
- [ ] radiation
- [ ] catching
- [ ] bucking
- [ ] locking
- [ ] grinding
- [ ] stiffness
- [ ] popping
- [ ] right pain
- [ ] bruising
- [ ] discoloration

**What hand is dominant?** (Select one)
- [ ] right handed
- [ ] left handed
- [ ] ambidextrous (both)

**Have you had any diagnostic tests done?** (Select all that apply)
- [ ] Yes
- [ ] No
- [ ] X-ray
- [ ] CT
- [ ] MRI

**Do you currently have numbness and tingling?**
- [ ] Yes
- [ ] No

**If yes, where?** (Select all that apply)
- [ ] right upper extremity
- [ ] left upper extremity
- [ ] right lower extremity
- [ ] left lower extremity

Additional Comments:
# Home Environment

**How would you rate your health?**
- excellent
- good
- fair
- poor

**Do you exercise regularly?**
- does
- does not

**How many falls have you had in the past 6 months?**
- 0
- 1 to 2
- >3

**What is your employment status?**
- employed
- unemployed
- retired

If yes, what do you do for a living?

**Do you live alone?**
- alone
- with someone

**Do you require assistance at home?**
- Yes
- No

**Do you have stairs at home?**
- Yes
- No

If yes, how many?
- 1-8
- 9-15
- >15

Where is the railing as you go up the stairs? (Select all that apply)
- left
- right

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# Goals/Followup

**What are your goals for therapy?**

**When are you scheduled to return to the doctor for follow-up?**
- as needed
- after completion of therapy
- within 1 month

**Additional Comments:**