HISTORY & SYSTEM REVIEW

BODYWORKShfr.com

Name: _____ Referred By: _____ Date: _____

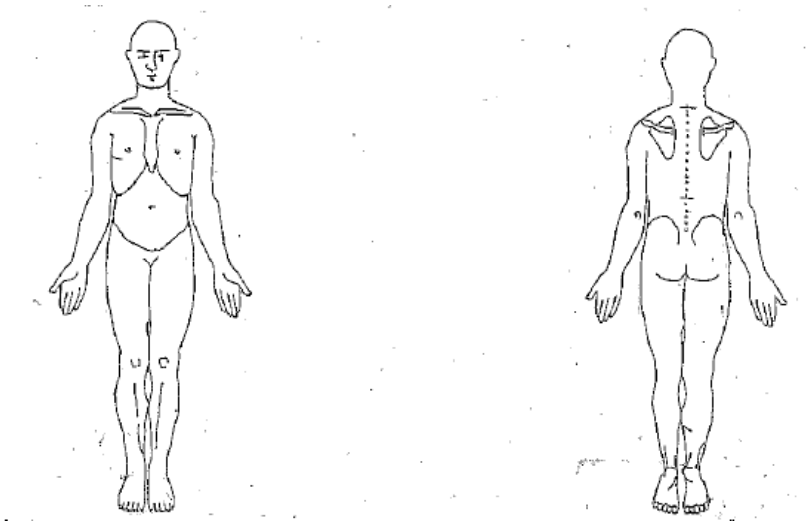
How did you hear about BODYWORKS? _____

Providing the requested information will help us understand your present condition and the impact it has had on your life. Your answers will help to guide our examination and will ensure that this evaluation is as accurate as possible. If you have any questions as you are completing this worksheet, please place a question mark there and your Clinician will discuss those areas.

HISTORY OF CURRENT CONDITION

1. What is your main physical complaint/problem? _____
2. When did your symptoms first begin? _____
3. How did your symptoms initially present themselves? _____
4. Was the onset of this episode… ☐ From injury* ☐ Disease ☐ Other:
5. How were you injured?* _____

   Shade any areas of pain or abnormal sensation(s) on the body chart below.



6. Was the onset of this episode…? ☐ Gradual ☐ Delayed ☐ Sudden _____
7. Since the onset, are your symptoms…? ☐ Better ☐ Unchanged ☐ Worse _____
8. How is your pain? (Check all that apply.) ☐ Dull ☐ Aching ☐ Throbbing ☐ Sharp
   ☐ Constant ☐ Periodic ☐ Constant _____
9. Does the pain wake you at night? ☐ No ☐ Yes
10. If yes, it is present when you are… ☐ Lying still ☐ When changing position ☐ Both
11. In what position do you sleep? ☐ Left side ☐ Right Side ☐ On Stomach ☐ On Back
    ☐ In Recliner or Chair Other: _____
12. Do you have pain/stiffness upon getting out of bed? ☐ Yes ☐ No
13. As the day progresses, is your pain… ☐ Decreased ☐ The Same ☐ Increased

14. What aggravates your pain/symptoms? (Check all that apply.)

☐ Sitting	☐ Reaching overhead	☐ Coughing/sneezing
☐ Going to/rising from sitting	☐ Reaching out from body	☐ Taking a deep breath
☐ Standing	☐ Reaching behind back	☐ Talking
☐ Squatting	☐ Reaching across body	☐ Yawning
☐ Lying down	☐ Doing repetitive activities	☐ Chewing
☐ Sleeping	like:_____	☐ Swallowing
☐ Walking	☐ Playing sports, such as:	☐ Feeling stressed
☐ Going up/down stairs	_____	☐ Other:
☐ Bending (sustained)	☐ Doing household chores	_____
☐ Looking up overhead	_____	_____

Notes

15. What relieves your pain/symptoms? (Check all that apply.)

☐ Sitting	☐ Playing Sports, such as:	☐ Alcohol
☐ Going to/rising from sitting	_____	☐ Medication
☐ Standing	☐ Cold	☐ Rests
☐ Squatting	☐ Heat	☐ Elevating limbs
☐ Lying down	☐ Whirlpool	☐ Nothing
☐ Walking	☐ Massage	☐ Other:
☐ Stretching	☐ Traction	_____
☐ Exercising	☐ Wearing Splints/Orthosis	_____

HISTORY OF CURRENT CONDITION

16. How many times have you had symptoms similar to your current condition? _____

17. What previous treatment have you had for this condition? (Check all that apply.)

☐ None	☐ Bracing/taping	☐ Work conditioning
☐ Medication (oral)	☐ Casting	☐ Biofeedback
☐ Physical therapy	☐ Traction	☐ TENS unit
☐ Massage therapy	☐ Injection into the spine	☐ Acupuncture
☐ Exercise	☐ Injection into skin/muscles	☐ Bed rest
☐ Joint Manipulation by a Chiropractor or Osteopath	☐ Surgery (on the body area Of your current problem)	☐ Overnight hospitalization Other

18. Which health professionals are you currently seeing?

Type	Name	Type	Name
☐ Medical/Family Doctor	_____	☐ Physical Therapist	_____
☐ Chiropractor	_____	☐ Massage Therapist	_____
☐ Orthopedist	_____	☐ Psychiatrist/Psychologist	_____
☐ Neurologist/Neurosurgeon	_____	☐ Other:	_____

19. Which of the following problems have you experienced? (Check all that apply.)

☐ Weakness/tingling/numb in both arms at same time	☐ Weakness/tingling/numb in both legs at same time	☐ Fever
☐ Unexplained weight loss	☐ Falling/balance problems	☐ Visual disturbances
☐ Numbness in genitals/anus	☐ Dizziness or fainting	☐ Ringing in the ears
		Other:

FUNCTIONAL LEVELS

For each of the questions below, read the question and answer it twice. First answer how it was for you were *before* the incident/accident/surgery (check the hollow box □) AND then how things are *now* (check the gray box ■).

Living Situation

□ ■ Have stairs in the home/outside
□ ■ Live in a house
□ ■ Live in an apartment
□ ■ Live in a mobile home
□ ■ Live in a facility that offers care
□ ■ Live alone
□ ■ Live with your spouse or a relative
□ ■ Other

Equipment Needed/Use

□ ■ Cane
□ ■ Walker
□ ■ Wheelchair
□ ■ Grab Bars
□ ■ Elevated/Bedside Commode
□ ■ Hospital Bed
□ ■ Other

Occupational Situation

□ ■ Employed full-time
□ ■ Self-employed
□ ■ Full-time homemaker
□ ■ Employed part-time
□ ■ Retired
□ ■ Disabled
□ ■ Unemployed

Time Taken Off From Work

_____

Work Related Physical Activities

□ ■ Sitting
□ ■ Using a computer
□ ■ Talking on the phone
□ ■ Driving
□ ■ Moving in a specific repetitive way
□ ■ Lifting 50+ pounds
□ ■ Lifting repetitively
□ ■ Operating heavy equipment
□ ■ Other

General Activity

Daily Living / Self Care Activities

□ ■ Perform all activities alone
□ ■ Require some assistance
□ ■ Need help for some activities
□ ■ Need help for all activities

Activities Outside The Home

□ ■ Often active with others outside home
□ ■ Occasionally active outside home
□ ■ Rarely active outside the home
□ ■ Need help for activities outside home

Exercise / Physical Activities

Frequency

□ ■ 5+ days per week
□ ■ 3-4 days per week
□ ■ 1-2 days per week
□ ■ Rarely
□ ■ Never

Your Sports & Recreational Activities

□ ■ Walking
□ ■ Aerobics
□ ■ Biking
□ ■ Swimming
□ ■ Weight Lifting
□ ■ Running
□ ■ Stationary Biking
□ ■ Stretching/Yoga
Pilates
□ ■ _____

DIAGNOSTIC TESTS

Test	Where	When	Results
□ X-Rays			
□ MRI			
□ CT Scan			
□ Bone Scane			
□ Arthrogram			
□ EMG			
□ Other:			

PRESCRIPTIONS & OVER THE COUNTER MEDICATIONS (Provide a list or write down any pills, injections, patches, herbs, etc.)

Prescription Medications	Over The Counter Medications/Treatments

PAST MEDICAL/SURGICAL HISTORY

20. How's your general health?

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Notes

21. Which of the conditions below have you ever been diagnosed with? (Check all that apply.)

☐ Heart problems	☐ Multiple Sclerosis	☐ Anemia
☐ High blood pressure	☐ Rheumatoid Arthritis	☐ HIV/Aids
☐ Diabetes	☐ Other Arthritic Conditions	☐ Epilepsy/Seizures
☐ Cancer	☐ Hepatitis	☐ Allergies
☐ Asthma	☐ Tuberculosis	☐ Depression/Mental Illness
☐ Emphysema/Bronchitis	☐ Stroke	☐ Anorexia/Bulimia
☐ Thyroid Problems	☐ Kidney Disease	☐ Chemical/Alcohol Addiction

☐ Other: _____

22. Which surgeries or other conditions have you been hospitalized for?

Date	Surgery/Hospitalization	Reason

23. Have you fallen within the last 12 months? ☐ Yes ☐ No

24. Which injuries (fractures, dislocations, sprains, etc.) have you been treated for recently?

Date	Treatment

25. Which describes an aspect of your current health?

☐ Have cardiac pacemaker ☐ Have metallic implants ☐ Have non-metallic implants

☐ Am pregnant Other:_____

FAMILY HISTORY

26. Has anyone in your immediate family (parents or siblings)? (Check all that apply.)

☐ Diabetes	☐ Tuberculosis	☐ Epilepsy/Seizures
☐ Heart Disease	☐ High Blood Pressure	☐ Depression/Mental Illness
☐ Stroke	☐ Kidney Disease	☐ Chemical/Alcohol Addiction
☐ Cancer	☐ Anemia	☐ Other:
☐ Arthritis	☐ Headaches	

DEMOGRAPHICS

27. Which of the following demographic designators describe you? (Check all that apply.)

☐ English speaking	☐ Non-English Speaking	Primary Language:_____
☐ White/Caucasian	☐ Non-Caucasian	Race: _____

Your Initials: _____ Date Completed: _____

ADDITIONAL INFORMATION

Please list any additional details you want us to know about.

SYSTEM REVIEW/CLINIC USE ONLY

Impression		Physical System
Not Impaired	Impaired	
☐	☐	Cardiovascular/Pulmonary System (HR, RR, BP, Edema)
☐	☐	Integumentary System (Integrity, Scar Formation, Color, Pliability)
☐	☐	Muscloskeletal System (Gross Strength, ROM, Symmetry) Height _____ Weight _____ BMI _____
☐	☐	Neuromuscular System (Balance, Gait, Location, Transfer, Transitions, and Motor Function)
☐	☐	Communication, Affect, Cognition, Learning Style System (Communication, Person/Place/Time Orientation Emotional/Behavioral Responses, Learning Barriers, Educational Needs)

CLINICIAN NOTES

Reviewing Clinician's Initials: _____ Date Reviewed: _____