

# HISTORY & SYSTEM REVIEW

Name: \_\_\_\_\_ Referred By: \_\_\_\_\_ Date: \_\_\_\_\_

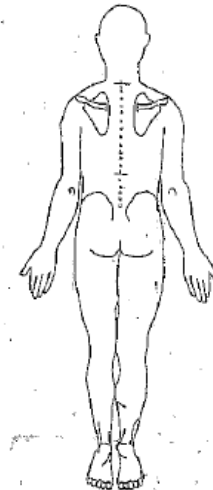
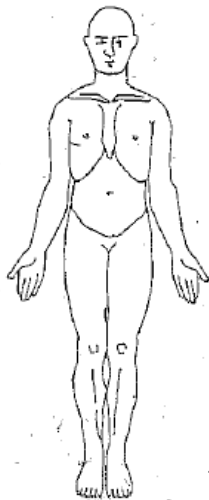
How did you hear about BODYWORKS? \_\_\_\_\_

*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.)

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

Notes

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Sitting                      | <input type="checkbox"/> Playing Sports, such as: | <input type="checkbox"/> Alcohol         |
| <input type="checkbox"/> Going to/rising from sitting | _____   | <input type="checkbox"/> Medication      |
| <input type="checkbox"/> Standing                     | <input type="checkbox"/> Cold                     | <input type="checkbox"/> Rests           |
| <input type="checkbox"/> Squatting                    | <input type="checkbox"/> Heat                     | <input type="checkbox"/> Elevating limbs |
| <input type="checkbox"/> Lying down                   | <input type="checkbox"/> Whirlpool                | <input type="checkbox"/> Nothing         |
| <input type="checkbox"/> Walking                      | <input type="checkbox"/> Massage                  | <input type="checkbox"/> Other:          |
| <input type="checkbox"/> Stretching                   | <input type="checkbox"/> Traction                 | _____                                    |
| <input type="checkbox"/> Exercising                   | <input type="checkbox"/> 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.)

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

18. Which health professionals are you currently seeing?

- | <u>Type</u>                                       | <u>Name</u> | <u>Type</u>  | <u>Name</u> |
|---|-------------|--|-------------|
| <input type="checkbox"/> Medical/Family Doctor    | _____       | <input type="checkbox"/> Physical Therapist        | _____       |
| <input type="checkbox"/> Chiropractor             | _____       | <input type="checkbox"/> Massage Therapist         | _____       |
| <input type="checkbox"/> Orthopedist              | _____       | <input type="checkbox"/> Psychiatrist/Psychologist | _____       |
| <input type="checkbox"/> Neurologist/Neurosurgeon | _____       | <input type="checkbox"/> Other:                    | _____       |

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Weakness/tingling/numb<br>in both arms at same time | <input type="checkbox"/> Weakness/tingling/numb<br>in both legs at same time | <input type="checkbox"/> Fever               |
| <input type="checkbox"/> Unexplained weight loss                             | <input type="checkbox"/> Falling/balance problems                            | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Numbness in genitals/anus                           | <input type="checkbox"/> Dizziness or fainting                               | <input type="checkbox"/> Ringing in the ears |
|  |  | Other:                                       |

**FUNCTIONAL LEVELS**

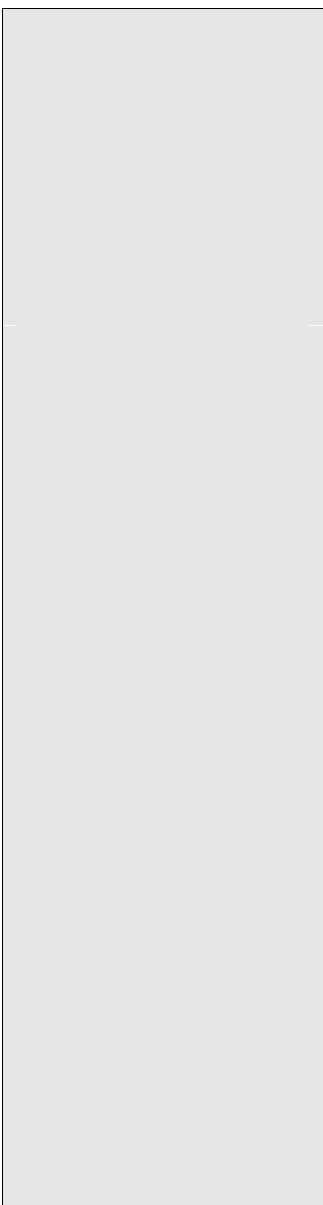
For each of the questions below, read the question and answer it twice. First answer how it was for you were *before* the incident/accident/surgery (check the hollow box ) AND then how things are *now* (check the gray box ).

Living Situation	
<input type="checkbox"/> <input type="checkbox"/> Have stairs in the home/outside	<input type="checkbox"/> <input type="checkbox"/> Live alone
<input type="checkbox"/> <input type="checkbox"/> Live in a house	<input type="checkbox"/> <input type="checkbox"/> Live with your spouse or a relative
<input type="checkbox"/> <input type="checkbox"/> Live in an apartment	<input type="checkbox"/> <input type="checkbox"/> Other
<input type="checkbox"/> <input type="checkbox"/> Live in a mobile home	
<input type="checkbox"/> <input type="checkbox"/> Live in a facility that offers care	
Equipment Needed/Use	
<input type="checkbox"/> <input type="checkbox"/> Cane	<input type="checkbox"/> <input type="checkbox"/> Wheelchair
<input type="checkbox"/> <input type="checkbox"/> Walker	<input type="checkbox"/> <input type="checkbox"/> Grab Bars
<input type="checkbox"/> <input type="checkbox"/> Elevated/Bedside Commode	<input type="checkbox"/> <input type="checkbox"/> Hospital Bed
<input type="checkbox"/> <input type="checkbox"/> Other	

Occupational Situation	
<input type="checkbox"/> <input type="checkbox"/> Employed full-time	<u>Work Related Physical Activities</u>
<input type="checkbox"/> <input type="checkbox"/> Self-employed	<input type="checkbox"/> <input type="checkbox"/> Sitting
<input type="checkbox"/> <input type="checkbox"/> Full-time homemaker	<input type="checkbox"/> <input type="checkbox"/> Using a computer
<input type="checkbox"/> <input type="checkbox"/> Employed part-time	<input type="checkbox"/> <input type="checkbox"/> Talking on the phone
<input type="checkbox"/> <input type="checkbox"/> Retired	<input type="checkbox"/> <input type="checkbox"/> Driving
<input type="checkbox"/> <input type="checkbox"/> Disabled	<input type="checkbox"/> <input type="checkbox"/> Moving in a specific repetitive way
<input type="checkbox"/> <input type="checkbox"/> Unemployed	<input type="checkbox"/> <input type="checkbox"/> Lifting 50+ pounds
Time Taken Off From Work	<input type="checkbox"/> <input type="checkbox"/> Lifting repetitively
_____	<input type="checkbox"/> <input type="checkbox"/> Operating heavy equipment
	<input type="checkbox"/> <input type="checkbox"/> Other

General Activity	
<u>Daily Living / Self Care Activities</u>	<u>Activities Outside The Home</u>
<input type="checkbox"/> <input type="checkbox"/> Perform all activities alone	<input type="checkbox"/> <input type="checkbox"/> Often active with others outside home
<input type="checkbox"/> <input type="checkbox"/> Require some assistance	<input type="checkbox"/> <input type="checkbox"/> Occasionally active outside home
<input type="checkbox"/> <input type="checkbox"/> Need help for some activities	<input type="checkbox"/> <input type="checkbox"/> Rarely active outside the home
<input type="checkbox"/> <input type="checkbox"/> Need help for all activities	<input type="checkbox"/> <input type="checkbox"/> Need help for activities outside home

Exercise / Physical Activities	
<u>Frequency</u>	<u>Your Sports &amp; Recreational Activities</u>
<input type="checkbox"/> <input type="checkbox"/> 5+ days per week	<input type="checkbox"/> <input type="checkbox"/> Walking
<input type="checkbox"/> <input type="checkbox"/> 3-4 days per week	<input type="checkbox"/> <input type="checkbox"/> Running
<input type="checkbox"/> <input type="checkbox"/> 1-2 days per week	<input type="checkbox"/> <input type="checkbox"/> Stationary Biking
<input type="checkbox"/> <input type="checkbox"/> Rarely	<input type="checkbox"/> <input type="checkbox"/> Stretching/Yoga
<input type="checkbox"/> <input type="checkbox"/> Never	<input type="checkbox"/> <input type="checkbox"/> Pilates
	<input type="checkbox"/> <input type="checkbox"/> Weight Lifting
	<input type="checkbox"/> <input type="checkbox"/> _____



**DIAGNOSTIC TESTS**

Test	Where	When	Results
<input type="checkbox"/> X-Rays			
<input type="checkbox"/> MRI			
<input type="checkbox"/> CT Scan			
<input type="checkbox"/> Bone Scane			
<input type="checkbox"/> Arthrogram			
<input type="checkbox"/> EMG			
<input type="checkbox"/> 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



