Spokane Sports and Physical Therapy
HISTORY AND INTERVIEW

Patient Name:_____ **Date:**_____

1. **HOW** did your problem begin?_____

_____

2. **WHAT** are your primary complaints?_____
3. Past/present treatments for this condition:_____
4. Past/present medical history, please list:_____
5. Please list all Medications:_____

_____

6. Make a mark (-) along the line to the right from extremes "No Pain At All" and "Pain As Bad As It Could Be", indicating your current pain level in your major area of injury. ⟶
7. Have you had similar problems in the past? Yes_____ No_____

If so, please explain:_____

8. What is your occupation/hobbies?_____
9. Are you currently working? Yes_____ No_____

If not, is it due to your condition? Yes_____ No_____

10. Just prior to the onset where you completely free of symptoms? Yes_____ No_____
11. Does anything in particular make you pain **worse?** Yes_____ No_____

If so, what?_____

_____

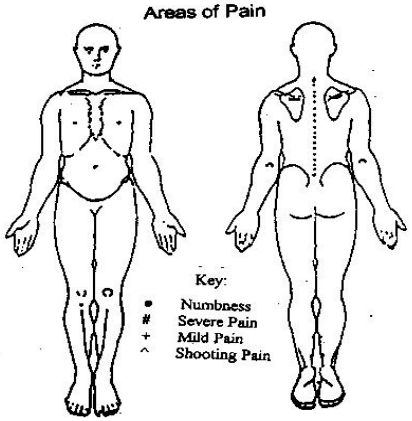
12. Does anything ease your pain? Yes____ No____

If so, what?_____

_____

13. Are you able to get comfortable at night? Yes_____ No_____
14. How do you feel upon rising in the morning? Stiff_____ Sore_____ Fine_____
15. Once you start moving about does it Worsen_____ Ease_____
16. What is it like at the end of the day? Worse_____ Easier_____

Areas of Pain



Pain as Bad as it could be

No Pain at All

17. At this time, do you feel that you are getting? Better_____ Worse_____ No Change_____
18. Comments:_____

_____