



Diagnosis: _____

Occupation/Job Duties: _____

Work Status: (circle one)

Off because of problems Light Duty Still Working Retired Not Employed

Date of onset: _____ Symptoms persisted for: _____

History of present illness/surgery: _____

Location of pain: _____

Frequency of pain: _____

Type of pain:

(burning, sharp, shooting, deep, superficial, aching, pins & needles, constant, intermittent, other)

Intensity of pain: 0=no pain, 10=excruciating pain: Please circle

At rest	0	1	2	3	4	5	6	7	8	9	10
With Activity	0	1	2	3	4	5	6	7	8	9	10

Does pain affect your sleep? Yes / No How? _____

Similar problems in the past: _____

In the past week has the pain: _____ increased _____ decreased _____ remained the same

Symptoms eased by: (circle all that apply)

Rest, heat, ice, exercise, medication, nothing, other: _____

Symptoms aggravated by: (circle all that apply)

Sitting, standing, walking, bending, lifting, activity, other: _____

Is there any activity you normally do that you are unable to do now because of your problem? _____

Completed by _____

Reviewed by/Date _____

PRESENT HISTORY QUESTIONNAIRE PT OT

FORM#17271 02/2004

