Oregon | Neurology
Associates

To save time in your registration process, please fill out and print this form and bring it with you to the clinic for your appointment. If unable, you will be able to fill out the form when you arrive for your appointment.

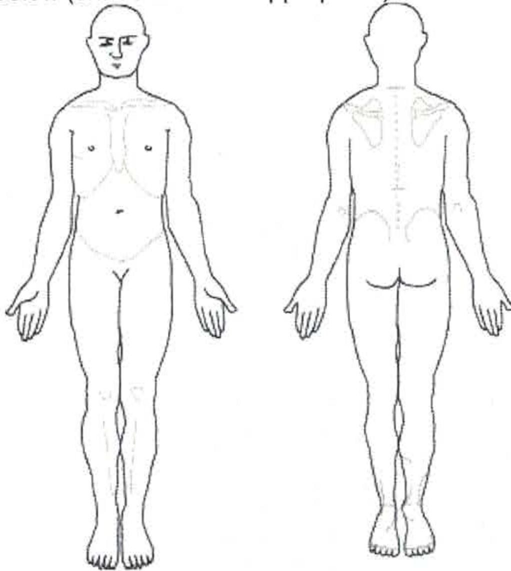
NAME:______________________ DATE:______________

HISTORY OF PRESENT CONDITION

To ensure that you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

1) Reason for visit? ____________________________

Localize areas of **pain** or **abnormal** sensation on the body chart below (shade in where appropriate)



2) When did your symptoms begin? __________
(Please indicate a specific date if possible)

3) Was the **onset/timing** of this episode?
❒ gradual ❒ sudden
Any previous episodes ❒ Yes ❒ No

4) Which of the following best describes how your injury occurred? *(If you condition is post-surgical, please indicate as per original injury)*
❒ unknown ❒ degenerative process
❒ while Lifting ❒ an incident at work
❒ MVA (car accident) ❒ dental appointment
❒ a fall ❒ during recreation/sports
❒ trauma ❒ overuse (cumulative trauma)
❒ other____________________

5) Since the onset, are your symptoms? (Check one)
❒ improving ❒ not changing ❒ worsening

6) Have you had any fall(s) in the past year? ❒ No
❒ Yes, how many times _____ ; ❒ injured ❒ not injured

7) Nature of pain/symptoms (check all that apply)
❒ sharp ❒ aching ❒ constant
❒ dull ❒ periodic ❒ other__________
❒ throbbing ❒ occasional

As the day progresses, do your symptoms: (Check one)
❒ increase ❒ decrease ❒ stay the same

Does the pain wake you at night?
❒ No ❒ Yes If "yes", is it present
❒ while lying down ❒ only when changing positions
❒ both

Do you have pain/stiffness upon getting out of bed in the morning? ❒ Yes ❒ No

8) In what position do you sleep? (Check all that apply)
❒ back, sides, stomach ❒ right side
❒ left side ❒ on stomach
❒ on back ❒ chair/recliner

9) Since the onset of your current symptoms have you had: (Check all that apply)
❒ any difficulty with bowel or bladder function
❒ fever/chills
❒ numbness in the genitals or anal area
❒ numbness
❒ any dizziness or fainting
❒ unexplained weakness
❒ unexplained weight change
❒ night pain/sweats
❒ malaise (vague feeling of bodily discomfort
❒ problems with vision/hearing
❒ none of the above

10) What aggravates your symptoms? (Check all that apply)
❒ sitting ❒ going to/rising from sitting
❒ walking ❒ up/down stairs
❒ standing ❒ squatting
❒ lying down ❒ sleeping
❒ looking up overhead ❒ sustained bending
❒ reaching overhead ❒ reaching in front of body
❒ reaching behind back ❒ reaching across body
❒ repetitive activity ____________________
❒ household activity ____________________
❒ recreation/sports including ________________
❒ coughing/sneezing ❒ taking a deep breath
❒ talking ❒ chewing ❒ yawning ❒ swallowing
❒ stress

11) What relieves your symptoms? (Check all that apply)
❒ nothing ❒ medication ❒ wearing splint/orthosis
❒ rest ❒ cold ❒ heat
❒ sitting ❒ standing ❒ walking ❒ lying down
❒ stretching ❒ exercise ❒ massage

PREVIOUS FUNCTIONAL LEVEL

- ☐ **Independent in all activities** (work, community, home, recreation)

Self Care

- ☐ Independent in all self-care (bathing, toileting, dressing, etc.) activities
- ☐ Have difficulty performing self-care activities
- ☐ Need assistance with self-care activities
- ☐ Have difficulty performing household chores

Social

- ☐ Need assistance with activities in community outside of home

Hobbies:______________________________

____

WORK HISTORY

Occupation______________________________

☐ (1) employed full time ☐ (5) student
☐ (2) employed part time ☐ (6) retired
☐ (3) self employed ☐ (7) unemployed
☐ (4) homemaker ☐ (8) other ____________

Physical activities at work

☐ (1) sitting ☐ (6) computer use
☐ (2) standing ☐ (7) heavy equipment operation
☐ (3) phone use ☐ (8) driving
☐ (4) repetitive lifting ☐ (9) other ______________
☐ (5) heavy lifting

Are you currently receiving for seeking disability for this condition? ☐ Yes ☐ No

If not performing your normal activities at work do you plan to RETURN to your previous activity level?
☐ Yes ☐ No

LIVING SITUATION

- ☐ (1) live alone
- ☐ (2) live with family member/others
- ☐ (3) live with caregiver
- ☐ (4) home/apartment
- ☐ (5) retirement complex (SNF/ ICF)
- ☐ (6) assisted living complex
- ☐ (7) other __________________

Setting

☐ (1) stairs railing ☐ (4) ramp
☐ (2) stairs no railing ☐ (5) elevator
☐ (3) no stairs ☐ (6) uneven ground
other ____________________________

GENERAL HEALTH

How would you rate your general health?
☐ Excellent ☐ Average ☐ Poor
☐ Good ☐ Fair

Do you exercise outside of normal daily activities?
☐ (1) 5+days/wk ☐ (4) occasionally
☐ (2) 3-4 days/wk ☐ (5) zero
☐ (3) 1-2days/wk

Exercise, Sports/Recreation consisting of ____________

____

Do you drink caffeine containing beverages?
☐ No ☐ Yes How many/much per day? ________

Do you smoke?
☐ No ☐ Yes Packs of cigarettes a day? _______

What is your stress level?
☐ Low ☐ Medium ☐ High

Are you seeing any health care providers other than the physical therapist for this current condition?(list)

____

____

PAST MEDICAL HISTORY

Have you ever had/ been diagnosed with any of the following conditions?

☐ Cancer (type)_________ ☐ Heart Problems
☐ Depression ☐ High blood pressure
☐ Stroke ☐ Lung Problems
☐ Kidney Problems ☐ Blood Disorders
☐ Thyroid problems ☐ Epilepsy/Seizures
☐ Diabetes ☐ Allergies
☐ Multiple Sclerosis ☐ Rheumatoid arthritis
☐ Arthritis ☐ Osteoporosis
☐ Head Injury ☐ Broken bone
☐ Stomach problems ☐ Other ______________
☐ Parkinson's Disease
☐ Circulation/vascular problems
☐ Infectious Diseases (i.e. hepatitis, tuberculosis)

Please list any recent/relevant past surgeries related to your current problem:

SURGERY **DATE**

____

____

____

FAMILY HISTORY

Has anyone in your immediate family *(parents, brothers, sisters)* ever been treated for any of the following?

☐ Diabetes ☐ Cancer
☐ Heart disease ☐ Arthritis
☐ High blood pressure ☐ Osteoporosis
☐ Stroke ☐ Psychological Condition
☐ Other ________________________________