Livingston HealthCare
Billings Clinic Affiliate

Name:____________________________________ **Date:**__________________

Welcome!

What brings you to therapy?____

____

When did your symptoms begin?____

What are some important activities you are having difficulty performing as a result of your symptoms?
(For example, climbing stairs, reaching overhead, getting out of a chair, walking, sitting, hiking, grooming, etc.)

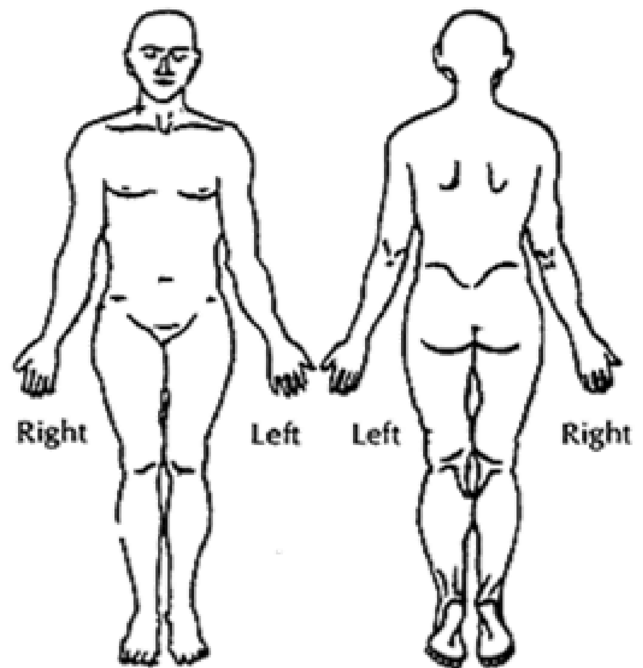
____

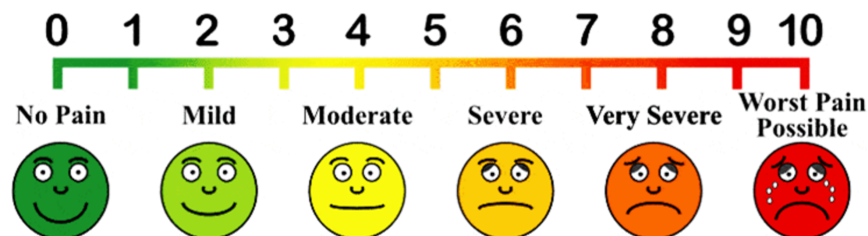
What types of symptoms are you having?
□ Numbness □ Tingling □ Burning
□ Throbbing □ Sharp and stabbing pain
□ Dull and aching pain Other:_____________

What makes your symptoms feel better?
□ Heat □ Ice □ TENS unit
□ Exercise □ Activity □ Rest
□ Walking □ Standing □ Sitting
□ Changing positions □ Pain medicine
□ Topical pain relievers Other:_____________

What makes your symptoms feel worse?
□ Activity □ Rest □ Changing positions
□ Walking □ Standing □ Sitting
□ Prolonged positions Other:_____________

Mark the locations of symptoms on the body chart:





Using the pain scale above, please write the number that best reflects your:

1. Current pain level:_________
2. Highest pain level in the past 24 hours:__________
3. Lowest pain level in the past 24 hours:___________

Please fill out both sides →

Have you RECENTLY noted any of the following? Check all that apply.

□ Appetite changes
□ Balance loss while walking
□ Bladder changes (incontinence, retention, etc.)
□ Bowel changes (incontinence, constipation, etc.)
□ Dizziness or spinning (vertigo)
□ Fever, chills, or sweats
□ Headaches (recent onset)
□ Hearing changes
□ Lightheadedness, blacking out, or fainting
□ Malaise (general feeling of discomfort or uneasiness)
□ Nausea or vomiting
□ Numbness in genital or anal area
□ Pain at night
□ Shortness of breath
□ Swallowing difficulty
□ Vision changes (blurriness, double vision, etc.)
□ Weakness
□ Weight loss or gain (unexplained)

If you answered yes to anything in the above section, please explain:______________________________

____

Have you EVER been diagnosed with any of the following conditions? Check all that apply.

□ Allergy to latex
□ Allergy to tape or adhesives
□ Anemia
□ Asthma
□ Blood disorders:_____________________
□ Broken bone(s):_____________________
□ Cancer: type(s)_____________________
□ Chemical dependency (i.e. alcohol, drugs, etc.)
□ Circulation or vascular problems
□ Depression
□ Diabetes: circle type I or type II
□ Heart disease:______________________
□ High blood pressure
□ High cholesterol
□ Infectious disease (i.e. hepatitis, tuberculosis, HIV/AIDS, etc.):_____________________
□ Kidney problems:____________________
□ Liver problems:______________________
□ Lung problems:______________________
□ Multiple sclerosis: diagnosis date________
□ Osteoarthritis
□ Osteoporosis or osteopenia (weak bones)
□ Pacemaker inserted
□ Parkinson's disease: diagnosis date______
□ Pregnant (currently): due date__________
□ Rheumatoid arthritis
□ Seizure: date of most recent____________
□ Stomach or intestinal problems: ________
□ Stroke or TIA: date(s)_________________
□ Thyroid problems:____________________
□ Tobacco use: packs per day____________
□ Other:______________________________
□ Other:______________________________

____

During the past month, have you been feeling down, depressed or hopeless? □ **Yes** □ **No**

During the past month, have you been bothered by having little interest or pleasure in doing things?
□ **Yes** □ **No**

Does a partner, or anyone at home, hurt, hit or threaten you? □ **Yes** □ **No**

Are you currently taking blood thinning or anticoagulant medications? □ **Yes** □ **No**

Prescription and over-the-counter medications (feel free to skip this section if you have recently told a Livingston HealthCare physician ALL of the medications you are currently taking)**:**_______________________

____

Surgeries and conditions requiring hospitalization **Approximate month and year**

____

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____

Please fill out both sides →