PATIENT HISTORY

Name (**print**): ____ **Date**: ____/____/____

How did you hear about Dr. Higgins? Please be specific ____

Is this a second opinion visit? ____**YES** ____ **NO** **Referring Physician:** _________________________________

What is the reason for your visit today? _________________________________ **Side**: ____**Left** ____**Right**

Have you been seen before for this problem? ____ **YES** ____ **NO** **If so, was it an orthopedist?** _____

Is this related to an injury? _____ **YES; date of injury:** ____/____/____/ ____**NO** ____**UNKNOWN**

What type of injury? (i.e.; sport, car accident, work, other) ____

How long has this been going on? _______________ **Where is the pain/weakness?** ______________________

What are your current symptoms? ___________________________ **Height:** _________ **Weight:** __________

Circle all that apply:

Pain is: MILD MODERATE SEVERE SHARP DULL TINGLING RADIATING THROBBING POUNDING CONSTANT FREQUENT OCCASIONAL INTERMITTENT

Pain is worse: MORNING AFTERNOON EVENING AT NIGHT DOES NOT APPLY

I can do the activities below to the following scale:

1= with difficulty 2= with some difficulty 3= with great difficulty 4= can not do at all

Lying down:_____Sitting:_____Standing:______Walking:_____Jogging/Running:_____ Driving a car:_____ Dressing:____

Going up stairs: _____ Going down stairs: _____ Lifting/Carrying: _____ Overhead reaching: ______Housework: ______

What tests have you done so far? **(Please circle all that apply)**

NONE XRAYS MRI EMG BONE SCAN CT SCAN OTHER: _____________________________________

What treatments have you done so far? **(Please circle all that apply**): NONE THERAPY INJECTIONS

BRACE/SLING EXERCISES MEDICATION HEAT COLD CHIROPRACTOR SURGERY OTHER:____________

Surgery Date: _____/_____/_____ **Procedure performed?:** ____

What medications have you taken for this condition? _____________ **Do you have trouble sleeping?** ______

What is your current work status? ____________ **Has your problem affected your work?** _____YES ____NO

What one activity relieves your symptoms?____________________**Worsens symptoms?**________________

What can you not do because of your pain? (i.e; work, housework, sports, etc.) ________________________