3-YOUR PAST MEDICAL AND INJURY HISTORY

Yes	No	Where applicable please provide brief explanations below
___	___	Are you injured?_____
___	___	Have you been involved in any major accident(s) ?_____
___	___	Have you had any major surgery?_____
___	___	Have you had any bone or stress fracture? _____
		If yes, do you currently have any metal plates/pins or screws in place?_____
___	___	Have you had any foot or ankle problems/injuries?_____
___	___	Have you had any knee or hip problems/injuries?_____
___	___	Have you had any shoulder/elbow or wrist problems/injuries?_____
___	___	Have you had any other muscle/ligament or tendon problems/injuries?_____
___	___	Have you had any neck problems/injuries (e.g. whiplash)?_____
		If so please indicate the date:_____
___	___	Have you had any low back problems/injuries?_____
		If so please indicate the number of previous episodes: _____
		0-5 : _____ 6-10 :_____ 11+ :_____ most recent episode, date:_____
___	___	Are you currently off work due to pain or disability?_____
		If yes, how long have you been off?_____
___	___	Have you been diagnosed as hypermobile (excessive joint mobility) :_____

Is there any other longstanding medical condition or disability not already covered above that your therapist should be aware of (e.g. Parkinsons, MS, ME)?

_____

_____

4-YOUR SYMPTOM SPECIFIC HISTORY – optional section for injured clients

Do you experience pain or discomfort? Yes :_____ No :_____
If so, is it: constant?_____ intermittent?_____
Present since ?_____
What is your typical or average pain? (0 no pain- 10 worst possible pain) :_____
What is your pain right now? (0 no pain- 10 worst possible pain) :_____
Are you taking any pain relieving medication right now? Yes :_____ No :_____
Type of medication: pain killers : _____ anti-inflammatories : _____ other :_____
How often? as required : daily :_____ regularly :_____
Does the medication help? Yes : _____ No : _____
Overall is your pain: improving : _____ unchanging : _____ wosening : _____
Is it worse: morning : _____ afternoon : _____ at nigh :_____ no pattern of discomfort :_____
What makes your discomfort better (relieving factors):_____
What makes your discomfort worse (aggravating factors):_____

Please indicate with a X the area where you have pain
Please indicate with /// the area where you feel numbness