GENERAL QUESTIONAIRE

Name ________________________________ Age _____ Gender _____ Date_________
Occupation____

1. Medical Conditions: (check all that apply, past or current)
   ____None known
   ____Respiratory ____Asthma ____Emphysema ____ Other_______________
   ____Heart ____Coronary Artery Disease ___Heart attack/s ___Valve Problems
   ___Other____
   ____High Blood Pressure
   ____Stroke
   ____Stomach / GI ____Reflux ____Ulcer
   ____Kidney Disease
   ____Diabetes: ____Insulin ____ Oral Medication ____Diet
   ____Rheumatoid Arthritis ____Raynaud's ____Lupus ____Multiple Sclerosis
   ____Fibromyalgia ____ Gout
   ____Endocrine Disorder ____Thyroid (___Hypo ____Hyper)
   ____Lyme Disease
   ____Blood Disorder ____Bleeding Problem ____Anemia
   ____Hepatitis ____A ____B ____C
   ____Cancer ____
   ____Tumor/s ____Benign ____Malignant
   ____Osteopenia / Osteoporosis
   ____**R**eflex **S**ympathetic **D**ystrophy (**RSD**) or Complex Regional Pain Syndrome
   ____Neuropathy ___Neuritis
   ____Treatment for Pain Management
   ____Depression ____Alcoholism ____Drug Dependency
   ____Other____

2. Surgical History :
   .*Type of operation* *Date* *Hospital*
   ____
   ____
   ____

3. Current medications & dosage: (including over-the-counter, herbal, etc.)
   _________________________________ _______________________________
   _________________________________ _______________________________
   _________________________________ _______________________________
   _________________________________ _______________________________

4. Allergies: (medication, food, latex, etc.)
   ____
   ____

(OVER)

5. Is this problem related to ___ sports, ___work, ___auto, ___other ___________

6. Name the body part (s) that is (are) involved and indicate ***right*** or ***left***.
____

7. Describe the problem (pain, swelling, numbness, etc.).
____
____

8. Was there a specific injury? If so please describe the injury.
____
____

9. When did the injury or problem first appear? Month_____ Day_____ Year_____

10. Who first saw you and evaluated your injury? When? ________________
____ Emergency Room Physician ____ Coach or trainer
____ Family Physician ____ Other ________________________
____ Orthopaedic Surgeon

11. What was the first diagnosis after your injury or problem?
____
____

12. Did you have any testing for this injury or problem (x-ray, MRI)? Please specify.
____

13. What other treatments, if any, have you received for this problem? (physical therapy, brace, etc.)____
____

14. Have you had problems in the past with this (these) body part (s)?
____

15. What is the nature of your pain? (dull, sharp, burning, throbbing, aching)
____

16. Do you notice that this body part has any temperature changes? (hot, cold)
____

17. Do you notice any skin color changes? If yes where? ____________________
____

18. Is light touch to skin painful? _______________________________________

19. Does ice application cause increased pain? (yes, no)_____________________