Patient Present Illness/Injury Questionnaire

ACTIVITIES OF DAILY LIFTING

Indicate Your Ability to Perform the Following Activities. Please Use These Codes.

U-Unable **L**-Limited **P**-Painful **D**-Difficult **N**-Normal **H**-Haven't Tried

1.___Lying on Back
2.___Lying on Side
3.___Lying Flat on Stomach
4.___Turning Over in Bed
5.___Getting In/Out of Car
6.___Reaching
7.___Gripping
8.___Climbing
9.___Pulling
10.___Dressing Self
11.___Sexual Activity
12.___Sleeping
13.___Pushing
14.___Kneeling
15.___Stooping
16.___Sitting (work,home)
17.___Bending Forward
18.___Walking Short Distances
19.___Bending to Brush Teeth
20.___Standing 1+ hours
21.___Balancing
22.___Cough/Sneeze/Grunt
How?_____
Where?_____

FILL OUT NEXT SECTIONS AS THEY APPLY TO YOU

HEADACHE

Yes No
Do You Experience:
___ ___ Nausea, Vomiting, or Visual Disturbances?
___ ___ Radiation (travel) of Pain from Neck?
___ ___ Pain/Clicking in Jaw?
___ ___ Abnormal Blood Pressure?
___ ___ Family History of Headaches?
Frequency of Headaches:_____
Date of Last Eye Exam: ____/_____

LUMBOLSACRAL SPINE (Lowback)

Yes No
___ ___ Feeling of Ripping or Tearing?
Where?_____
___ ___ Does the Pain Radiate (travel) to the Abdomen?
___ ___ Does the Pain Radiate (travel) into the Leg?
___ ___ Impairment of Bowel or Bladder Function?
Explain:_____

CERVICAL SPINE (Neck)

Yes No
___ ___ Neck Injury that Affects Hearing, Vision, Balance or Causes Ringing in Ears?
___ ___ Do You Hear Grating Sounds?

Yes No
___ ___ Difficulty Turning Head? __Right __Left
___ ___ Pain/Pressure Behind Eyes?
___ ___ Feeling of Ripping/Tearing

WHAT ARE YOUR GOALS? Office Use Only

- **Condition #1:**_____
  Goal #1:_____
  _____
  Goal #2:_____
  _____
- **Condition #2:**_____
  Goal #1:_____
  _____
  Goal #2:_____
  _____

Physician Signature:_____ Date: ____/____/_____