OMT TRAINING

Case History - please fill out to the best of your ability

Name: _____ Date: _____

Age: _____ Occupation: _____

Current Injury/Condition – *Check which applies*

1. Work
Car Accident ___ Sports _ Other __

2. Sudden Onset ___
Gradual Onset _____

3. When did your injury/condition occur? _____

4. Area of original injury/condition? _____

5. Has the injury/condition spread? _____

6. How are the symptoms since onset? Better_____
Same_____ Worse_____
7. Has this injury/condition happened before? Yes_____

History of Treatment

1. Any current medication(s) for this problem:
_____

2. Any medication(s) for other problem(s):
No_____

_____

3. X-rays for current problem? Yes ____ No ____ _____
Results
4. Any other tests for current problem (CT scan, MRI, EMG, DxUS): Yes No __ __

_____

Describing the Pain

1. Aching _____
Burning _____
Throbbing _____ Stabbing _____ Tingling _____
2. Deep _____ or Superficial _____

3. Constant _____ or Intermittent _____

Therapist's Comments
(Please do not fill in)

Therapist's Comments

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On a scale of zero (no pain) to ten (worse pain imaginable) describe the intensity of your pain:

At its Worse: 1 2 3 4 5 6 7 8 9 10 At its Best

Assessing your Symptoms

Therapist's Comments

1. Aggravating factors (what makes your pain worse)?

_____

2. Alleviating factors (what makes your pain better)?

_____

3. Worst time of the day is?

_____

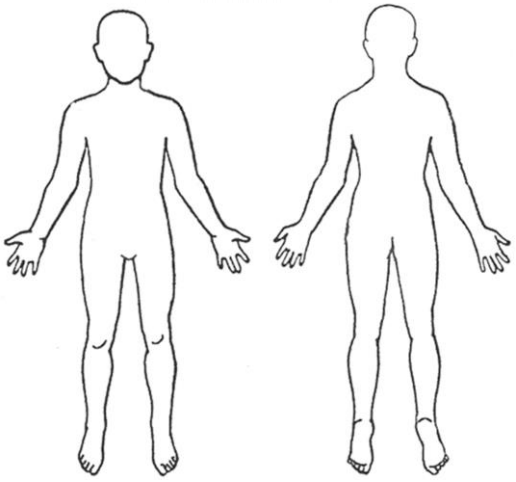
Morning _____
Afternoon_____
Evening_____
Night_____

4. Does the pain disrupt your sleep? Yes ____No ____

Describing your Symptoms

Draw circles around the affected body parts, and indicate the letter which best describes your symptoms.

Discomfort =
D Soreness =
So Stiffness =
St Spasm =
Sp Tightness =
T Tingling =
Ti Numbness =
N Weakness =
W Pain = P
Other = _____
(Add your own description)



Describing patient Occupation - *Check which applies*

1. Place of employment: _____

2. Job Title: _____

Check those that applies to patient's job:

3. Sedentary _____Active _____Very Active _____

4. Prolonged sitting _____Prolonged Standing _____
Prolonged Walking _____

5. Repetitive Lifting _____
Repetitive Bending _____Repetitive Twisting _____
Repetitive Carrying _____

6. Are you currently: Off Work _____

On Modified Hours/Duties _____

Describing Activities Outside Work

Type/ frequency of exercise: _____

Please advise your Physiotherapist/Doctor of Chiropractic if any of the following conditions exist as they may interfere with your treatment.

Do you have:

Yes	No	Metal Implants such as pins, plates, and/or wire
Yes	No	Pace Maker or Defibrillator
Yes	No	Joint Replacement

Have you ever had or are you currently being treated for:

Yes	No	High Blood Pressure
Yes	No No No	Low Blood Pressure Diabetes
Yes	No No	Tuberculosis
Yes		AIDS
Yes		Hepatitis Type
Yes		
Yes	No No No	Heart Problems
Yes		Kidney Problems
Yes		Cancer: Where and When _____
Yes	No	Hyper or Hypothyroidism
Yes	No	Stroke: When _____
Yes	No	Hemophilia

Are you on any medication or using topical applications regularly such as:

Yes	No	Cortisone (pills or recent injections)
Yes	No	Aspirin
Yes	No	Tranquilizers
Yes	No	Muscle Relaxants
Yes	No	Pain Killers
Yes	No	Tetracycline
Yes	No	Antibiotics
Yes	No	Liniment

Do you have any allergies that you are aware of? Please List

Do you have any other medical conditions that you want us to be aware of?

For Women Only:

Yes No Do you suspect you may be pregnant?

Name: _____

_____

_____

Signature: _____

Date: _____