AIM REHABILITATION CENTRE

25 Redmond Dr. Unit 7, Hamilton, Ontario, L8W3K7

Case History

Patient Name:_____ Date:_____

Current Complaint:

1. When did the injury/pain start: _____

2. Location of Pain: _____

3. Cause: _____

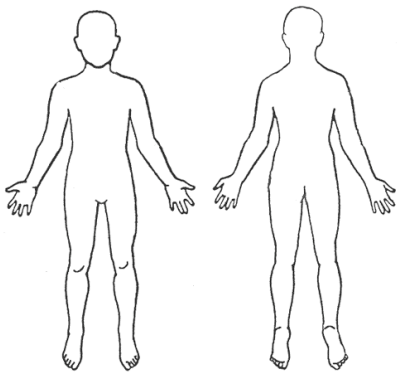
4. Did the pain come on Suddenly:____ or Slowly over time: _____

5. Do you experience radiating/referred pain?:_____

6. Is the pain/injury getting: better____ worse ____ no change_____

7. Past history of similar complaint:_____

NOTES (for office use):



Please Describe Your Complaint:

1. Sharp___ Dull ___ Aching____Burning___Other:_____

2. Constant_____Intermittent_____

3. Intensity of pain: on a scale of 0 to 10

0 1 2 3 4 5 6 7 8 9 10

no pain ⟷ worst imaginable pain

4. Aggravating factors (what increases pain):

_____

5. Relieving Factors (what makes you feel better):

_____

6. Does the pain wake you during sleep: Yes __ No___

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Treatment History:

1. Have you received any treatment for this condition/injury? Yes_____ No_____

Type: _____

2. Do you take any medication(s) for this injury/complaint? Yes____ No____

Please list:_____

3. Have you had any x-rays, ultrasound, MRI, CT scan for this complaint: Yes____ No____

Please list: _____

Occupation:

1. Type of Work/Employment:_____

2. Are you? off work_____ on modified work_____ modified hours_____

Health Status Survey:

<u>Do you have or have you had any of the following (please circle):</u>

Vision Problems
Breathing/Respiratory Problems
Heart/Circulatory Problems
High blood pressure
Low blood pressure
Gastro/Intestinal Problems
Kidney Problems
Diabetes
Thyroid problems
Cancer
Stroke
Bleeding Disorders
Tuberculosis
HIV/AIDS
Hepatitis: Type____
Other:_____

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Case History

Health Status Survey Continuation

Do you have any allergies? Yes No _____

Do you exercise/play sports? Yes No _____

Are you a smoker? Yes No _____

Do you drink alcohol? Yes No _____

Are you on any medications? Yes No _____

For Women: Do you suspect to be pregnant? Yes No

Notes (for office use)
Patient medical family history:

For office use: Provider:_____

Patient Name: _____ Date:_____