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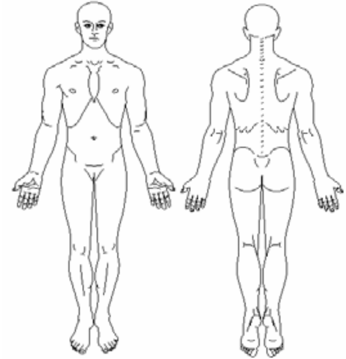
Musculoskeletal History Form

Your Name: ______________________________________ Date: ___________________

Is your current problem the result of: Auto Accident? Yes No
Work Accident? Yes No

Circle the location(s) of your symptoms



For *EACH* area of pain/complaint please answer the following questions:

Problem #1: State problem (Example: low back or neck pain) _________________________________

When did it start? ____

What do you think is the cause? ____

Rate how severe your pain is **right now, at this moment**
0 1 2 3 4 5 6 7 8 9 10
No pain Severe pain

Rate how severe your pain is **at its worst**
0 1 2 3 4 5 6 7 8 9 10
None Excruciating

Rate how severe your pain is **on the average**
0 1 2 3 4 5 6 7 8 9 10
None Excruciating

Rate how **frequently** you experience pain
0 1 2 3 4 5 6 7 8 9 10
Rarely All the time

Describe pain: □ Sharp/Stabbing Burning □ Throbbing □ Shooting □ Tingling Dull □ Numb Sore □ Ache □ Weak

Since it began, is your problem: □ Improving □ Getting Worse □ No Change

What makes your problem better? Nothing Lying Down Walking Movement Exercise Inactivity/Rest Other:_______

What makes your problem worse? Nothing Lying Down Walking Movement Exercise Inactivity/Rest Other _______

Can you perform your daily home and/or work activities: Yes, all activities Only with help A limited amount Not at all

Have you been treated for this recently? Yes No, If yes, what type of treatment? ____

Have you ever been treated for the same/similar problem? If yes, when & where? ____

Problem #2: (Example: head ache or mid back pain) ____

When did it start? ____

What do you think is the cause? ____

Rate how severe your pain is **right now, at this moment**
0 1 2 3 4 5 6 7 8 9 10
No pain Severe pain

Rate how severe your pain is **at its worst**
0 1 2 3 4 5 6 7 8 9 10
None Excruciating

Rate how severe your pain is **on the average**
0 1 2 3 4 5 6 7 8 9 10
None Excruciating

Rate how **frequently** you experience pain
0 1 2 3 4 5 6 7 8 9 10
Rarely All the time

Describe pain: □ Sharp/Stabbing Burning □ Throbbing □ Shooting □ Tingling Dull □ Numb Sore □ Ache □ Weak

Since it began, is your problem: □ Improving □ Getting Worse □ No Change

What makes your problem better? Nothing Lying Down Walking Movement Exercise Inactivity/Rest Other:_______

What makes your problem worse? Nothing Lying Down Walking Movement Exercise Inactivity/Rest Other _______

Can you perform your daily home and/or work activities: Yes, all activities Only with help A limited amount Not at all

Have you been treated for this recently? Yes No, If yes, what type of treatment? ____

Have you ever been treated for the same/similar problem? If yes, when & where? ____