

Eclipse Orthopaedic Rehabilitation Patient History Form

Today's Date: _____

Patient Name: _____

Date of Injury: _____ Occupation: _____

Job Requirements: _____ Is this a work related injury: _____

If yes please explain: _____

Description of Problem:

Aggravating Factors:

Relieving Factors:

List of previous treatment/tests for this problem (MRI or X-Rays):

Indicate on the Diagrams the area(s) or location(s) where you are currently experiencing symptoms. Use the key to help fill out the diagram:



Key: P = Pins and needles
S = Stabbing sensation
B = Burning sensation
A = Ache sensation

Please use the three scales below to rate the intensity of your pain.
0 = no pain 10 = need to go to the emergency room now

Right Now: 0 1 2 3 4 5 6 7 8 9 10

Worst in last 24 hours: 0 1 2 3 4 5 6 7 8 9 10

Best in last 24 Hours: 0 1 2 3 4 5 6 7 8 9 10

List All Medical Conditions:

List Past Surgeries:

List all Medications:

Review of Systems

Please place a check opposite any problems you may have:

Poor balance
High Blood Pressure
Leg pain or Sciatica
Emphysema
Loss of bowel/Bladder control
Depression
Dislocated Joints

Chest pains or Angina
Seizures
Easy Bleeding or Bruising
Lung Cancer
Anxiety
Diabetes
Broken Bones

Anemia
Calf pain when walking
Asthma
Stroke
Swelling in multiple joints
Fibromyalgia

Cancer: _____
Reflex Sympathetic Dystrophy
Weakness or loss of sensation in arms or legs