

**UCR Health Centers Website Registration
Patient Medical History - Rehabilitation**

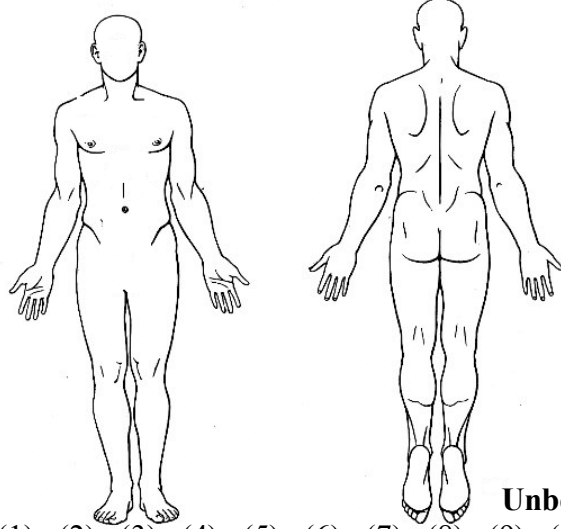
Patient Name: _____

Date Symptoms Started: _____

Describe Your Symptoms and How They Began: _____

How often do you experience your symptoms? Indicate where you have pain or other symptoms.

- (1) Constantly (76% - 100% of the day)
- (2) Frequently (51% - 75% of the day)
- (3) Occasionally (26% - 50% of the day)
- (4) Intermittently (0% - 25% of the day)



What describes the nature of your symptoms?

- (1) Sharp
- (2) Shooting
- (3) Dull ache
- (4) Burning
- (5) Numb
- (6) Tingling

How are your symptoms changing?

- (1) Getting Better
- (2) Not Changing
- (3) Getting Worse

How bad are your symptoms at their: Worst:

None Unbearable

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

Best: (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

How do your symptoms affect your ability to perform daily activities?

(0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
No Complaints Mild, forgotten with activity Moderate, interferes with activity Limiting, prevents full activity Intense, preoccupied with seeking relief Severe, no activity possible

What activities make your symptoms worse: _____

What activities make your symptoms better: _____

Who have you seen for your symptoms?

- (1) No One
- (2) Family Doctor
- (3) Urgent Care
- (4) Physical Therapist
- (5) Other

a.) Date and treatment performed: _____

b.) What tests have you had for your symptoms and when were they performed?

- (1) X-Rays date: _____
- (2) MRI date: _____
- (3) CT Scan date: _____
- (4) Other date: _____

Have you had similar symptoms in the past? (1) YES (2) NO

a.) If you received treatment for these same symptoms in the past, who did you see?

- (1) Urgent Care
- (2) Primary Care Doctor
- (3) Chiropractor
- (4) Physical Therapist
- (5) Other

What is your occupation? _____

What is your current work status? (1) Full Time (2) Part Time (3) Self-Employed (4) Unemployed

What do you hope to get from your visit/treatment (select all that apply):

- (1) Reduce Symptoms
- (2) Explanation of condition/treatment
- (3) How to prevent this from occurring again
- (4) Resume/increase activity
- (5) Learn how to take care of this on my own

Patient Signature _____

Date _____