RIVERDALE
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Riverdale, GA 30296
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ABSOLUTE HEALTHCARE & REHAB CENTER

MCDONOUGH
902 Pavilion Court
McDonough, GA 30253
(678) 583-9583
Fax: (678) 583-1083

CURRENT HEALTH CONDITION

NAME: _____ **DATE:** _____

Primary Complaint: _____

How would you describe the pain? (check all which apply)

☐ Dull ☐ Sharp ☐ Burning ☐ Stabbing ☐ Shooting ☐ Throbbing ☐ Stiff ☐ Aching ☐ Heavy ☐ Other_____

How would you rate severity of the pain?

☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Secondary Complaint: _____

How would you describe the pain? (check all which apply)

☐ Dull ☐ Sharp ☐ Burning ☐ Stabbing ☐ Shooting ☐ Throbbing ☐ Stiff ☐ Aching ☐ Heavy ☐ Other_____

How would you rate severity of the pain?

☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU CURRENTLY HAVE:

☐ **Neck:**
☐ Stiff ☐ Pain
☐ **Shoulder Pain**
☐ Left ☐ Right ☐ Both
☐ **Arm Pain**
☐ Left ☐ Right ☐ Both
☐ **Arm-Hand Numbness or Tingling**
☐ Left ☐ Right ☐ Both
☐ **Muscle spasm in Neck/Shoulders**

☐ **Headaches:**
☐ Constant ☐ Episodic
☐ Sharp ☐ Dull
☐ Aching ☐ Throbbing
☐ Dizzy ☐ Light-headed
☐ Nausea ☐ Vomiting
☐ Fainting ☐ Forgetfulness
☐ Ringing in the ears ☐ Blurred vision

How Would you Rate the Headaches?
☐ Mild ☐ Mod ☐ Severe

☐ **Mid-Back:**
☐ Stiff ☐ Pain
☐ **Pain Between Shoulders**
☐ **Chest-Rib Pain**
☐ **Shortness of Breath**
☐ **Muscle spasm in Mid-Back**
☐ **Tension**

General:
☐ **Sleeping problems**
☐ **Nervousness**
☐ **Fatigue**
☐ **Irritability**
☐ **Depression**
☐ **Excessive Thirst**
☐ **Difficult Chewing / Clicking Jaw**
☐ **Stomach pain**
☐ **Poor / Excessive Appetite**

Other Problems
☐ _____
☐ _____

☐ **Low-back:**
☐ Stiff ☐ Pain
☐ **Leg Pain**
☐ Left ☐ Right ☐ Both
☐ **Leg Numbness or Tingling**
☐ Left ☐ Right ☐ Both
☐ **Foot Numbness or Tingling**
☐ Left ☐ Right ☐ Both
☐ **Muscle spasm in Low-Back**
☐ **Buttock Pain/Sore**
☐ **Abdominal Cramps / Upset Stomach**
☐ **Excessive Gas / Flatulence**
☐ **Constipation**
☐ **Diarrhea**
☐ **Black / Bloody Stool**
☐ **Discolored Urine**

FEMALES ONLY:
☐ **Pregnant?**
☐ Yes ☐ No ☐ Not Sure
Date of Last Menstrual Period _____
Number of Children: _____

When Did This Condition Begin? _____

Have You Seen Other Doctors For This Condition: ☐ Yes ☐ No **Who?** _____

Drugs You Taking for THIS condition:
☐ Pain Killers ☐ Anti-inflammatory ☐ Muscle Relaxer ☐ Nerve Pills ☐ Other _____

Is This Condition Due to:
☐ Job Related ☐ Auto Accident ☐ Home Injury ☐ Fall ☐ Other: _____

If Job Related Have You Made a Report of Your Accident To Your Employer? ☐ Yes ☐ No _____

Occupation / Type of Work: _____

Work Activities: ☐ Sitting ☐ Standing ☐ Bending ☐ Stooping ☐ Twisting ☐ Light Labor ☐ Moderate Labor ☐ Heavy Labor

Exercise / Activities: ☐ None ☐ Moderate Activity (2-3x / week) ☐ Heavy Activity (4-7x / week) ☐ Weight Training ☐ High impact