# ACUTE MUSCULOSKELETAL PAIN / PREREQUISITES

**Reason for coming:** _____

**Name:** _____

**Date of birth:** _____

**Working status**: Are you currently…

☐ **1.** working ☐ **2.** sick leave ☐ **3**. retired ☐ **4.** unemployed ☐ **5.** student
☐ **6.** other, what? _____

**Profession** _____ **Describe your work task**_____

_____

**Please answer to following questions by marking the best option**

**Do you have any doctor's diagnosed disease?**

| | | | |
|---|---|---|---|
| Cardiovascular disease | ☐ No | ☐ Yes | _____ |
| Hypertension | ☐ No | ☐ Yes | _____ |
| Metabolic syndrome /diabetes | ☐ No | ☐ Yes | _____ |
| Neurological disease | ☐ No | ☐ Yes | _____ |
| Musculoskeletal disease | ☐ No | ☐ Yes | _____ |
| Respiratory disease | ☐ No | ☐ Yes | _____ |
| Migraine | ☐ No | ☐ Yes | _____ |
| Rheumatism | ☐ No | ☐ Yes | _____ |
| Thyroid disease | ☐ No | ☐ Yes | _____ |
| Malign tumor | ☐ No | ☐ Yes | _____ |
| Mental disorder | ☐ No | ☐ Yes | _____ |
| Allergy | ☐ No | ☐ Yes | _____ |
| Osteoporosis | ☐ No | ☐ Yes | _____ |
| Other general disease | ☐ No | ☐ Yes | _____ |

**Have you suffered from any following symptoms lately?**

| | | | | | |
|---|---|---|---|---|---|
| Fever | ☐ No | ☐ Yes | Weight loss | ☐ No | ☐ Yes |
| General condition decrease | ☐ No | ☐ Yes | Chest pain in exertation | ☐ No | ☐ Yes |
| Breathing pain | ☐ No | ☐ Yes | Dizziness, Vertigo | ☐ No | ☐ Yes |
| Constant headache | ☐ No | ☐ Yes | Changes in vision, side differences | ☐ No | ☐ Yes |
| Bacteria infection | ☐ No | ☐ Yes | Urinary and fecal incontinence, difficulty | ☐ No | ☐ Yes |
| Limb weakness | ☐ No | ☐ Yes | Upset stomach | ☐ No | ☐ Yes |
| Radiation pain to upper or lower limb | ☐ No | ☐ Yes | Stress, depression etc. | ☐ No | ☐ Yes |

**Do you smoke?** ☐ No ☐ Yes **Are you pregnant?** ☐ No ☐ Yes

**Do you exercise regularly?** ☐ No ☐ Yes, what?_____

**Do you have regular medication?** ☐No ☐Yes

Medication _____ ☐No ☐Yes

**Have you been in an accident?** ☐No ☐Yes

What kind of accident and when? ☐No ☐Yes

_____

**Is this the first time you have these symptoms?** ☐No ☐Yes

**Have you been in surgery due to these symptoms?** ☐No ☐Yes

**Have you been in x-ray or MRI (magnetic resonance research) due to these symptoms?** ☐No ☐Yes

**How long you have had these current symptoms?**

1-6 days ☐ 1-3 weeks ☐ ~1 month ☐ 2–3 months ☐
over 3 months ☐ over 6 months ☐ over year ☐

**Have you used pain medication for your current pain?** ☐No ☐Yes

What medication?

_____

**Describe how current pain started** _____

_____

**What makes the pain worse?** _____

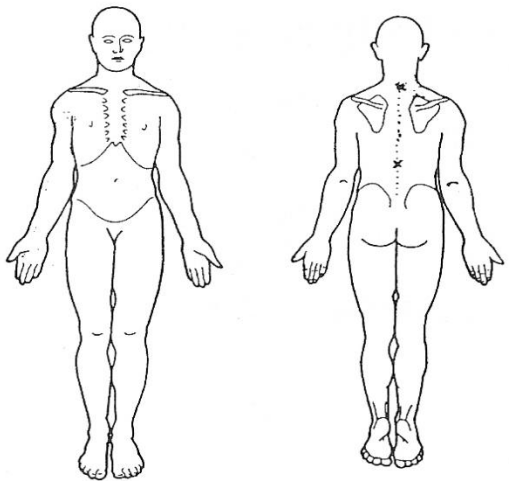
**What relieves pain?** _____

**How intense you pain has been for the last 7 days on average?**

Draw X on the following line where it best describes intensity of the pain.

*no pain* _____ the *worst pain*

**Please draw your current pain areas to the following picture. Use this mark /////.**



Date: _____ Signature: _____