# HISTORY OF PRESENT ILLNESS (HPI)

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**Today's Date:**_____

**Name:** **Date of Birth:** DD/MM/YYYY

**Chief Complaint (in your own words):** Why are you here today?

**Did you have an injury?** Yes No If yes, complete the injury section. If not, move to context section.

**INJURY** Where were you when your injury first occurred?

■ Home ■ School ■ Work ■ Auto Accident ■ Sports Injury ■ Gradually Occurred

Date injury occurred:_____

What were you doing when the injury first occurred? _____

What caused the injury? _____

**CONTEXT**

Are you currently experiencing pain? Yes No Does your problem awaken you from sleep? Yes No

Any daily activities limited because of the problem? Yes No If yes, which activities:

■ Dressing ■ Bathing ■ Using Bathroom ■ Getting up from bed/chair

Since the pain started, have you been able to work?

■ Unable to work ■ Able to work w/ restrictions
■ Temporary limitations– no restrictions now ■ No work restrictions

**LOCATION** What side of body? ■ Left ■ Right

What extremity are you being evaluated for today?

■ Shoulder ■ Wrist ■ Upper Arm ■ Elbow ■ Forearm ■ Leg ■ Upper Leg ■ Lower Leg

■ Neck ■ Hip ■ Hand ■ Back ■ Foot ■ Knee ■ Ankle

**QUALITY**

How would you describe the problem/pain?

| | | | | | |
|---|---|---|---|---|---|
| ■ Aching | ■ Burning | ■ Cold | ■ Cramping | ■ Crushing | ■ Heaviness |
| ■ Hot | ■ Popping | ■ Pressure | ■ Sharp | ■ Shock Like | ■ Shooting |
| ■ Sore | ■ Stabbing | ■ Stinging | ■ Throbbing | ■ Tightness | ■ Pins & Needles |

If your pain is radiating, how would you describe the pain?

■ Numbness and tingling ■ Numbness only ■ Tingling only

**SEVERITY**

On a scale from 1 to 10, how severe is the problem/pain? (1– Barely Feel It, 10 – Most Severe Pain Imaginable) _____

**DURATION**

Date symptoms began: _____

**TIMING** How would you describe the timing of your problem/pain?

■ Constant ■ Comes and goes ■ Only w/ movement ■ Pain has resolved

**MODIFYING FACTORS** What helps the pain?

■ Rest ■ Ice ■ Heat ■ Medication ■ Nothing ■ Other: ___

What medications are you taking for pain?

■ No Medications ■ Vicodin or Tylenol 3 ■ Percocet ■ Tylenol

■ Ibuprofen (Advil/Motrin) ■ Aleve/ Naprosyn ■ Other: _____

**AGGRAVATING FACTORS** What seems to aggravate the pain?

■ Exercise ■ Sitting ■ Standing ■ Walking ■ Repetitive Motions

■ Overhead activities ■ Coughing, Sneezing, Straining ■ Rest ■ Bending

■ Stair Climbing ■ Nothing ■ Other: _____

**ASSOCIATED SIGNS & SYMPTOMS** What symptoms have you developed because of the problem/injury?

■ Fever ■ Drainage ■ Nausea ■ Bleeding ■ Headache ■ Numbness/Tingling ■ Pain

■ Weakness ■ Joint Problems ■ Other:_____

Pain in other joints? No Yes If yes, list joints: _____

Are you able to walk stairs? No Yes

Do you use support? No Yes If yes, which do you use:

■ Cane ■ 2 Canes ■ Crutch ■ 2 Crutches ■ Walker ■ Wheelchair