Aquacare Physical Therapy
Health History and Pain Assessment

Name: _____ Date of symptom onset, injury or surgery: _____

Have you sought other treatment for this condition? YES NO If yes, please explain:

_____

Please list all medications and dosages: _____

_____

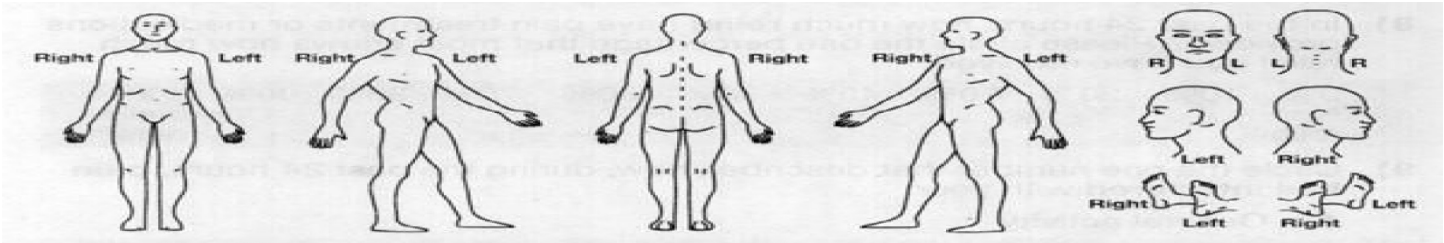
Please list any previous surgeries (type of surgery and year): _____

_____

Do you currently have, or have you ever had any of the following? Please check "yes" or "no".

	Y	N		Y	N		Y	N
AIDS/HIV			Foot Pain / Discoloration			Osteoarthritis		
Allergies			Headaches			Osteoporosis		
Alzheimer's Disease/Dementia			Heart Attack			Pacemaker/Defibrillator		
Asthma			Heart Disease			Parkinson's Disease		
Bowel or Bladder Irregularity			Hernia			Pregnant (CURRENTLY)		
Cancer			High Blood Pressure			Rheumatoid Arthritis		
CVA			High Cholesterol			Seizures		
Depression			Kidney Problems			Scoliosis		
Diabetes			Low Blood Pressure			Sensory Changes		
Dizziness or Balance Issues			Mental Illness or Disorder			Spinal Stenosis		
Falls (with or without injury)			Specify:			Thyroid Issues		
# of falls in the last year ___			Metal Implants			Urinary Leakage		
Fibromyalgia			Multiple Sclerosis			Other – Specify:		

Pain Chart & Questionnaire



1. Please indicate the location of your pain using the diagram above.

2. Please describe your pain (circle all that apply)

Constant Intermittent Sharp Dull Achy Burning Pins & Needles

3. Please rate your pain level using the scale 0 – 10. **0 = No Pain and 10= Worst Pain**

Current Pain: _____ Worst Pain: _____ Best Pain _____ Acceptable Pain:_____

4. Onset, duration, variations, rhythms: _____

5. What eases the pain? _____

6. What causes or triggers the pain? _____

7. Effects of pain? (i.e.decreased function, quality of life, etc) _____

8. Personal Pain Plan: _____

I certify to the best of my knowledge the above information is correct. I understand I will be provided with a description of my individualized physical therapy treatment plan. It will include the potential benefits and any associated risks of physical therapy. I understand that my attendance, in accordance with the prescribed treatment plan, is critical to maximizing the potential benefits of my physical therapy treatment plan. I have read and understand the above information and agree to consent to physical therapy treatment to be provided by Aquacare Physical Therapy personnel.

Patient Signature: _____ Date: _____

☐ Patient ☐ Legal Guardian ☐ Power of Attorney

Therapist Signature: _____ Date: _____