Health History and Pain Assessment

Name: _____ DOB: _____ Date of symptoms onset, injury or surgery: _____

Have you sought treatment for this condition? Yes No If yes, please explain: _____

_____

List all medications and dosages: _____

_____

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

_____

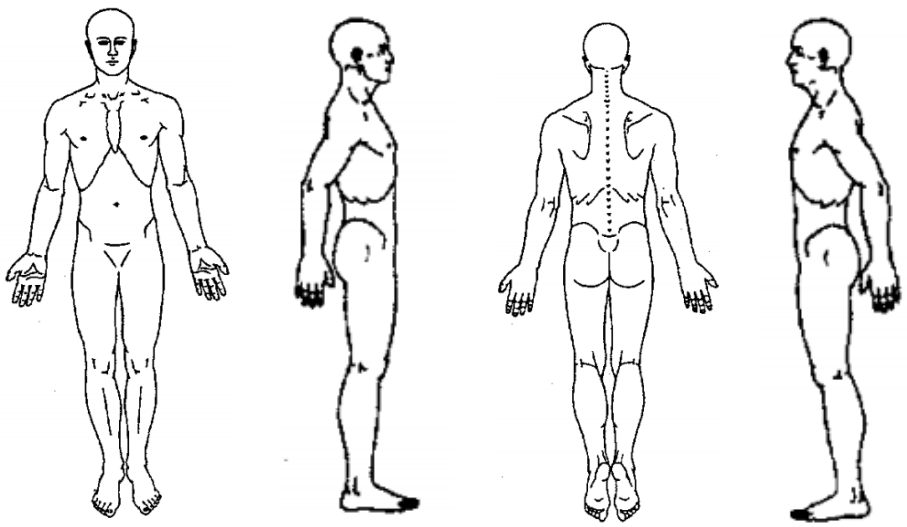
List any diagnostic testing performed pertaining to your current condition (XR, CT, MRI, VNG.): _____

_____

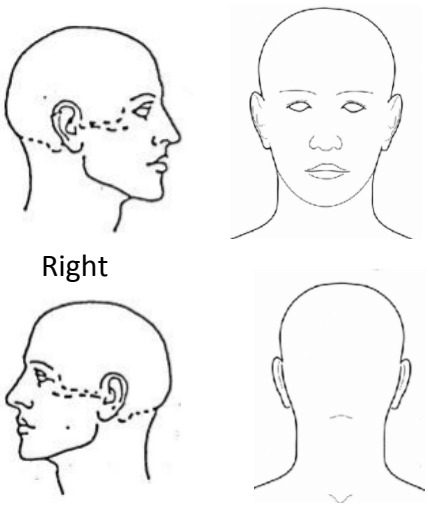
Medical History

	Yes	No		Yes	No		Yes	No
AIDS/HIV			Fibromyalgia			Muscular Dystrophy		
Allergies			Foot Pain/Discoloration			Obesity		
Alzheimer's/Dementia			Fracture			Osteoarthritis		
Asthma			Headaches			Osteoporosis		
Bipolar			Heart Attack			Pacemaker/Defibrillator		
Bowel/Bladder Irregularity			Hernia			Parkinson's Disease		
Cancer Type:_____			High Blood Pressure			Pregnancy (Currently)		
Cardiovascular Disease			High Cholesterol			Rheumatoid Arthritis		
Cauda Equina Syndrome			Huntington's Disease			Seizures		
CVA (Stroke)			Immunocompromised			Scoliosis		
Current Infection			Kidney Problems			Sensory Changes		
Depression			Low Blood Pressure			Spinal Stenosis		
Diabetes Type 1			Lupus			Thyroid Issues		
Diabetes Type 2			Mental Illness/Disorder			Traumatic Brain Injury		
Dizziness/Balance Issues			Specify:			Urinary Leakage		
Falls			Metal Implants			Other:		
# of falls in last year			Multiple Sclerosis					

1) Circle the location of your pain using the diagram below:



Right Left



Right Left

2) Describe your pain (circle one):

Constant Intermittent Sharp Dull Achy Burning Pins & Needles

3) Rate your pain level using the scale 0-10 (10 being the worst pain):

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

4) Onset, Duration, Variation, Rhythms: _____

5) What eases the pain? _____

6) What causes or triggers the pain? _____

7) Effects of pain (decreased function, quality of life, etc.): _____

8) Personal pain plan: _____

Social History

1) Marital Status: Single Married Divorced Widowed

2) Living Situation: Home Parents Assisted Living Facility Lives with Family Lives with Caregiver

3) Home Layout: 1-story 2-story Condo/Apt. Stairs/Steps Shower Stall Combo Bathtub/Shower

4) Is your living space handicap accessible? Yes No

Employment History

1) Are you employed: Yes No If yes, Name of Occupation: _____

Circle One: Full Time Part Time Light Duty Transitional Duty Out of Work Retired

2) Work Level (circle one): Sedentary Light Medium Heavy Very Heavy

3) Work Description: _____

4) Is this workman's comp? Yes No If yes, Date of injury: _____ Out of work since: _____

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.

Signature: _____ Date: _____

☐ Patient ☐ Legal Guardian ☐ Power of Attorney

Therapist Signature: _____ Date: _____