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): _____

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_____

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

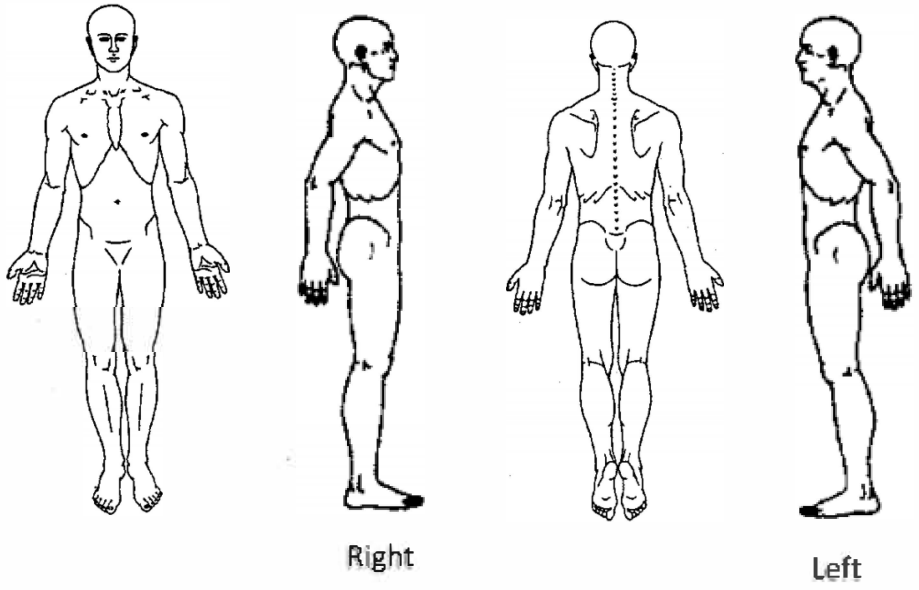
_____

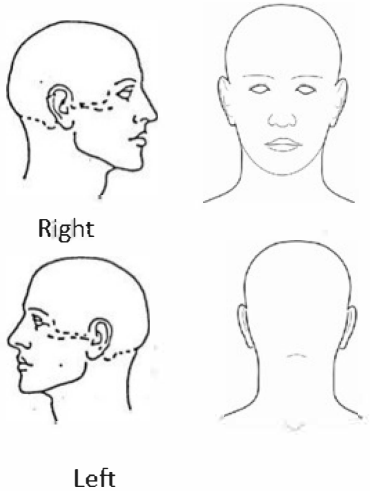
Medical History

Height _____ **Weight:**_____

	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:





Health History and Pain Assessment

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 Partnered Divorced Widowed

2) Living situation: Alone Parents Assisted Living Facility Lives with Family Lives with Caregiver Alone

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

5) Are you a tobacco user? 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: _____