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.): _____

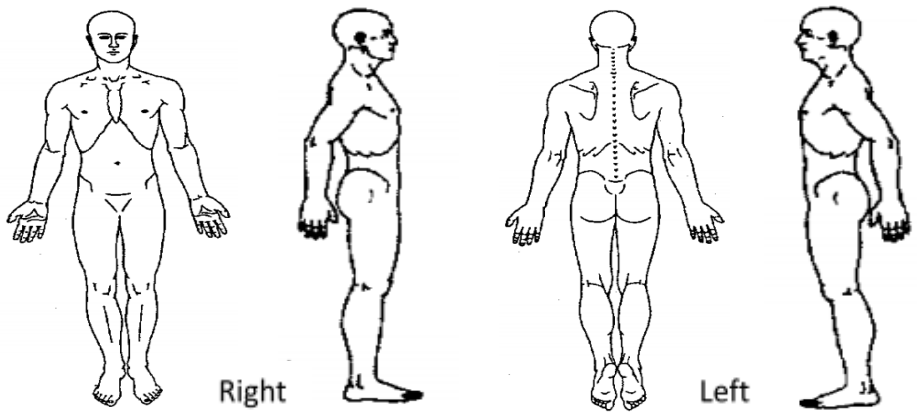
_____

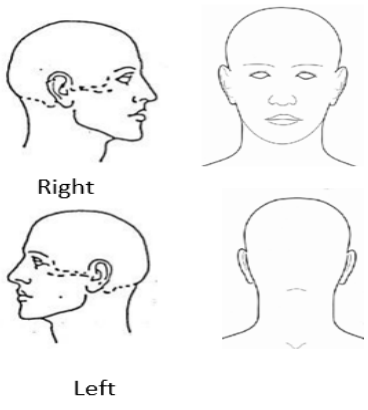
Medical History

Sex Assigned at Birth: ◯M ◯F (SELECT) **Preferred Pronoun: ◯He ◯She ◯They ◯Other: _____** (SELECT)

	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	◯	◯
			Metal Implants	◯	◯	Other:		
			Multiple Sclerosis	◯	◯			

Circle the location of your pain using the diagram below:





Health History and Pain Assessment

****Required Information****

1) Height _____ Weight _____ 2) Are you a tobacco user? **(select)** ◯ **Yes** ◯ **No**

3) How many times have you fallen in the last year? _____

4) Over the past 2 weeks, how often have you been bothered by any of the following problems? (select)	**Not at All**	**Several Days**	**More than Half the Days**	**Nearly Every Day**
A. Little interest or pleasure in doing things	◯ 0	◯ 1	◯ 2	◯ 3
B. Feeling down, depressed or hopeless	◯ 0	◯ 1	◯ 2	◯ 3

Pain Assessment

1) Describe your pain**(select one)** ◯ Constant ◯ Intermittent ◯ Sharp ◯ Dull ◯ Achy ◯ Burning ◯ Pins & Needles

2) Rate your pain level using the scale 0-10 **(10 being the worst pain)**: Current Pain: ____ Worst Pain: ____ Best Pain: _____

3) Onset, Duration, Variation, Rhythms: _____

4) What eases the pain? _____ 5) What causes or triggers the pain? _____

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

Social History

1) Marital Status: ◯ Single ◯ Married ◯ Partnered ◯ Divorced ◯ Widowed

2) Living Situation: ◯ Home ◯ 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

Employment History

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

(select one) ◯ Full Time ◯ Part Time ◯ Light Duty ◯ Transitional Duty ◯ Out of Work ◯ Retired

2) Work Level **(select 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: _____