Prime Physical Therapy

7516 Iron Bar Lane
Gainesville, VA 20155
Phone: (571)-261-9234
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Pain Assessment and Medical History Questionnaire

Name: ____ Age: _________ Date: _______________________

Reason for visit: _______________________________________ Date of Injury:____________________________

How you were injured/How did your symptoms start? ____

____

Have you had surgery?_______________________ If yes, Date of surgery: ______________________________

Previous Therapy:_________________ If Yes, When: _______________ How many visits: _________________

Has your condition been getting: Worse / Same / Better Do you have tingling or numbness?_________

Are your symptoms: Constant / Intermittent Is your sleep disturbed due to pain: ___________________

Have you had any diagnostic test(s) (circle all that apply): X-ray MRI CATSCAN

Have you had any injections for this condition?____________ If yes, When?______________________________

Please rate current pain level (circle): 0 1 2 3 4 5 6 7 8 9 10 (0= no pain, 10=worst imaginable pain)

Please rate pain level at its best (circle): 0 1 2 3 4 5 6 7 8 9 10 (0= no pain, 10=worst imaginable pain)

Please rate pain level at its worst (circle): 0 1 2 3 4 5 6 7 8 9 10 (0= no pain, 10=worst imaginable pain)

What decreases your pain?____

What increases your pain?____

____

What are your goals for physical therapy?____

____

Medical History

Please list any allergies: ____

Please list all medications: ____

____

Please circle Yes (Y) if you have any of the following conditions?

Anemia	Y	Hearing Impaired	Y	Thyroid Problems	Y
Anxiety	Y	High Cholesterol	Y	Vision Problems	Y
A-fib	Y	HIV/ADS	Y	Pacemaker	Y
Asthma	Y	Hepatitis A, B or C	Y	Blood clots	Y
Arthritis	Y	High/Low Blood pressure	Y	Leukemia	Y
Autoimmune Disorder	Y	Heart Problems	Y	Previous surgery	Y
Cancer	Y	Incontinence	Y	Hot/cold Intolerance	Y
Circulation Problems	Y	Kidney Problems	Y	Gout	Y
Currently Pregnant	Y	Metal Implants	Y	Ulcer	Y
COPD	Y	Multiple Sclerosis	Y	Weakness	Y
Depression	Y	Osteoporosis	Y	Skin Irritation	Y
Diabetes	Y	Parkinson's disease	Y	Metal Implants	Y
Emphysema/Bronchitis	Y	Rheumatoid Arthritis	Y	Breast Lumps/surgery	Y
Fibromyalgia	Y	Seizures	Y	Numbness/Tingling	Y
Fractures	Y	Stroke	Y	History of Blood Clot	Y
Headaches	Y	Smoking	Y	Vertigo	Y

Have you recently experienced any of the following (circle all that apply):

Unexplained weight loss Fatigue Nausea /Vomiting Significant Weakness Dizziness

Current Infection Vision/Hearing Changes Recent Hospitalization

Please list any other information we may need to know to better treat you:________________________________

____

Worker's Comp Information

(Only complete if this is a work-related injury)

Employer Name: ____ Phone: ____________________________

Address: ____

What is your regular job?____

What is your current job status? Not Working Lightwork Duties Full Work Duties

Prior to injury, what was your job status? Full-time Part-time PRN

How did your injury happen?____

____