

## Prime Physical Therapy

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## Pain Assessment and Medical History Questionnaire

Name:	Age:	Date:	
Reason for visit:	Date of I	njury:	
How you were injured/How did your symptoms start	t?		
Have you had surgery?	If yes, Date of surge	ry:	
Previous Therapy: If Yes, When	1:	_ How many v	isits:
Has your condition been getting: Worse / Same / B	Better Do yo	u have tinglin	g or numbness?
Are your symptoms: Constant / Intermittent	Is your sleep distur	bed due to pa	in:
Have you had any diagnostic test(s) (circle all that ap	oply): X-ray	MRI	CATSCAN
Have you had any injections for this condition?	If yes, Wh	ien?	
Please rate current pain level (circle): 0 1 2 3 4	5 6 7 8 9 10 (0	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 1	.0 (0= no pain	, 10=worst imaginable pain
What decreases your pain?			
What increases your pain?			
What are your goals for physical therapy?			

## **Medical History**

lease list all medications:    lease circle Yes (Y) if you have any of the following conditions?    Anemia	Please list any allergies:					
Anemia Y Hearing Impaired Y Thyroid Problems Y Anxiety Y High Cholesterol Y Vision Problems Y Anxiety Y High Cholesterol Y Vision Problems Y Anxiety Y High Cholesterol Y Vision Problems Y Asthma Y Hepatitis A, B or C Y Blood clots Y Anxiety Y Hepatitis A, B or C Y Blood clots Y Anxiety Y High/Low Blood pressure Y Leukemia Y Autoimmune Disorder 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 Incontinence Y Hot/Cold Intolerance Y Circulation Problems Y Kidney Problems Y Gout Y Currently Pregnant Y Metal Implants Y Ulter Y COPP Y Multiple Sclerosis Y Weakness Y Depression Y Osteoporosis Y Skin Irritation Y Diabetes Y Parkinsory Sidesses Y Metal Implants Y Diabetes Y Parkinsory Sidesses Y Metal Implants Y Emphysema/Bronchitis Y Rheumatoid Arthritis Y Breast Lumps/surgery Y Fibromyalgia Y Setures Y Numbness/Tingling Y Fractures Y Stroke Y History of Blood Clot Y Headaches Y Smoking Y Vertigo Y Vertigo Y Smoking Y Vertigo Y Smoking Y Vertigo	Please list all medication	ns:				
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ave you recently experienced any of the following (circle all that apply):  nexplained weight loss						
Worker's Comp Information	nexplained weight los	s I	Fatigue Nausea /Vo	miting	Significant Weakness	Dizziness
Worker's Comp Information (Only complete if this is a work-related injury)  mployer Name: Phone:  ddress:  what is your regular job?  what is your current job status? Not Working Lightwork Duties Full Work Duties  rior to injury, what was your job status? Full-time Part-time PRN	urrent Infection	,	/ision/Hearing Changes		Recent Hospitalization	
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