Spine and Sport Biomechanical Rehabilitation Center
Re-Evaluation Subjective Pain Form

Patients Name: _____ **Today's Date:** _____

Date of Birth: _____ **Age:** _____ **Date of Pain Onset:** _____

In order for us to better understand your symptoms/pain, please answer *every* question.

Please describe what you are currently experiencing and what you have experienced regarding your symptoms/pain:

_____

_____

_____

List 3 goals you hope to achieve with physical therapy in our clinic (functional activities / physical):

1. _____

2. _____

3. _____

List any surgeries, new injuries or other treatments since your last visit: _____

_____

_____

List all current medications and condition for medication below: _____

_____

_____

_____

(0 = No Symptoms/Pain 5 = Moderate 10 = Excruciating)

Today what is your current symptom/ pain level? **0 1 2 3 4 5 6 7 8 9 10**

What has your symptom/pain range been (best & worst) in the past 30 days? **0 1 2 3 4 5 6 7 8 9 10**

Do you have pain with coughing, sneezing, and/or bowel movements? YES NO (circle those that apply)

Do you have problems sleeping? YES NO **Explain:** _____

What is your best sleeping position? _____ **Worst?** _____

Symptoms increase with: _____

Symptoms decrease with: _____

What is your most tolerable position? (Circle) Lying Sitting Walking Standing All positions are the same

What is your least tolerable position? (Circle) Lying Sitting Walking Standing All positions are the same

Have you modified or discontinued any daily tasks? YES NO **Explain:** _____

_____

Do you currently use splints, braces, support orthotics? If so circle and describe: _____

Have you had diagnostic tests for pain/symptom? (Circle) X-Rays MRI CT Scan **Other**: _____

PLEASE USE BACK SIDE OF THIS FORM FOR ANY ADDITIONAL INFORMATION YOU FEEL WE SHOULD KNOW.