

Spine and Sport Biomechanical Rehabilitation Center- Subjective Pain Form

Patients Name: _____ Today's Date: _____

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

Please describe what you are currently experiencing or what you have experienced in the past regarding your complaint /pain:

List all areas of the body you are experiencing pain/discomfort:

What is your current pain level? (Circle) 0 1 2 3 4 5 6 7 8 9 10 (0 = Absence of Pain 5 = Moderate 10 = Excruciating)

What has your pain range been in the past 30 days? 0 1 2 3 4 5 6 7 8 9 10 Have you gone to ER due to the this pain? No Yes

Do you have any changes in bowel or bladder functions? No Yes If yes, state changes: _____

Do you have increased pain with coughing, sneezing, and/or bowel movements? No Yes *If yes, please circle those that apply.

Do you have problems sleeping? No Yes If yes, describe: _____

What is your best sleeping position? _____ What is your 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? No Yes If yes, what? _____

What is your current work status? NA Full Time Part Time Retired Off Work Current job description: _____

What physical activity do you currently engage in and how often? _____

Have you had any past treatments? Pain Mgmt. PT DO DC Manipulation Massage Other: _____

Do you currently use splints, braces, support orthotics? Describe: _____

Have you had diagnostic tests for complaint? (circle) None X-Rays MRI CT Scan Bone Scan EMG NCV Other: _____

Hand Dominance: (circle) Right Left Foot Dominance: (circle) Right Left

Do you have a pacemaker? Yes No ***If yes, please let our staff know before your appointment.

List history of medical traumas (falls, car accidents, sports injuries, broken bones etc.): _____

List ALL surgeries and approx. dates: _____

List systemic conditions (ex. diabetes, high blood pressure, asthma etc.): _____

List all current medications and condition for medication below: _____
