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:

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

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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 <u>before</u> your appointment.*

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

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List ALL surgeries and approx. dates: ________________________

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

List all current medications and condition for medication below: ________________________

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