Spine and Sport Biomechanical Rehabilitation Center- Subjective Pain Form

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

Date of Birth: ____________________ **Age:** ______ **Date of Pain Onset:** ____________________

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

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

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

1. ____

2. ____

3. ____

List ALL medical traumas (car accidents, sports injuries, falls, broken bones etc.): ______________________

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List ALL surgeries and approx. dates: ____

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What is your current symptom/pain level? (Circle) 0 1 2 3 4 5 6 7 8 9 10 **(0 = No Symptoms/Pain 5 = Moderate 10 = Excruciating)**

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

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

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) X-Rays MRI CT Scan Bone Scan 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 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.