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:

_____

_____

_____

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, please state:** _____

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? (Circle) NA Full Time Part Time Retired Off Work

Current job description:_____ **Marital Status:** Single Married Divorced Widowed

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

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

_____

_____

List any past surgeries and approx. dates: _____

_____

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

Have you had any past treatments? None Surgery Pain Mgmt. PT DO DC Manipulation Massage Other: _____

Do you currently use splints, braces, support orthodics? If so circle and 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

What are your expectations and goals seeking PT treatment at this facility? Is there any additional information we should know?

_____

_____

Do you have a pacemaker? Yes No (If yes, please let the therapist know during your appointment.)

List all current medications and condition for medication below:

_____

_____

_____

Please add any additional information you would like the therapists to know on the back.