Howard County MEDICAL CENTER

Date: __________

Patient Information:

Name:_______________________________________ Date of Birth:_____________

Gender: __M __F Age:________ Dominant Hand: __R __L

Height: ___ft. ___in. Weight: ______ Occupation: _________________________

Treating Physician: _______________________________________

Pain Assessment

<u>Please use Key to mark pain on body</u>

<u>Please put an X on the face of the pain level</u>

0 NO HURT | 2 HURTS LITTLE BIT | 4 HURTS LITTLE MORE | 6 HURTS EVEN MORE | 8 HURTS WHOLE LOT | 10 HURTS WORST

No pain | Moderate pain | Worst pain

0 1 2 3 4 5 6 7 8 9 10

<u>Key to body chart</u>:

Numbness	=======
Pins and Needles	00000000
Burning Pain	XXXXXX
Stabbing Pain	//////////////

1. Diagnosis as stated by Physician:____
2. Onset/Date of Injury:____
3. How the Injury happened:____
4. Chief Complaint:____
5. Surgery for present condition? ___YES ___NO If YES, date:_______________
   a. If YES, surgery type:____
6. Anything make pain **WORSE**:____
7. Anything make pain **BETTER**:____
8. Have you been treated for present condition before? ___YES ___ NO
   a. By whom: ____
9. Have you had any of the follow for present condition? ____XRAY ____MRI ____CT

Past Medical History (Circle YES or NO)

Have **YOU** ever had or currently have any of the following?

- Allergies YES NO
    - ________________________
- Ankle Injury/Surgery YES NO
- Angina YES NO
- Arthritis (RA, OA) YES NO
- Asthma YES NO
- Back Injury/Surgery YES NO
- Bleeding Disorder YES NO
- Bladder Changes YES NO
- Blood Clot YES NO
- Bowel Changes YES NO
- Cancer YES NO
    - ________________________
- COPD YES NO
- Heart Failure (CHF) YES NO
- Depression YES NO
- Diabetes YES NO
- Dizziness/Fainting YES NO
- Foot Injury/Surgery YES NO
- GERD YES NO
- Headaches YES NO
- Heart Attack YES NO
- High Blood Pressure YES NO
- Hypoglycemia YES NO
- Joint Replacement YES NO
    - ________________________
- Kidney Problems YES NO
- Knee Injury/Surgery YES NO
- Multiple Sclerosis YES NO
- Nausea/Vomiting YES NO
- Neck Injury/Surgery YES NO
- Osteoporosis YES NO
- PACEMAKER YES NO
- Parkinson's YES NO
- Pregnant (Current) YES NO
- Sleeping Problems YES NO
- Smoking YES NO
    - Currently YES NO
- Stroke or TIA YES NO
- Vascular Disease YES NO
- Visual Impairment YES NO
- Weakness YES NO

Have you had any falls in past year? ___YES ___ NO If YES, when and how? _____________
____

Goals of Physical Therapy: ____
____

Patient Signature: ________________________________ Date:______________