Gainesville Physical Therapy

Pain Assessment Form

Patient Information

Name: Age: Date:

Rehabilitation Information

1. Chief complaint / Ailment / Injury
2. How long have you had this problem: Date of Injury:
3. Have you had surgery? Date of Surgery:
4. Briefly describe how you were injured:

5. Have you received therapy for this condition? ☐ YES or ☐ NO If so, When?
   How many visits?
6. Has your condition been getting: ☐ Worse ☐ Same ☐ Better
7. Are your symptoms: ☐ Constant or ☐ Intermittent
8. Mark the number that best corresponds to your pain:

At Best: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (excruciating pain)

At Worst: ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 (excruciating pain)

9. What decreases/makes your condition better? (Check all that apply)

☐ Bending	☐ Movement	☐ Rest	☐ Better in the AM
☐ Sitting	☐ Standing	☐ Heat	☐ Better as day progresses
☐ Rising	☐ Walking	☐ Ice	☐ Better in the PM
☐ Changing positions	☐ Lying	☐ Medication	☐ N/A - Cast just removed

10. What increases/make your condition worse? (Check all that apply)

☐ Bending	☐ Movement	☐ Rest	☐ Sneeze
☐ Sitting	☐ Standing	☐ Stairs	☐ Deep Breath
☐ Rising	☐ Walking	☐ Cough	☐ Medication
☐ Prolonged Positioning	☐ Lying	☐ Worse in the AM	☐ Worse in the PM
☐ Worse as day progresses	☐ N/A - Cast just removed		

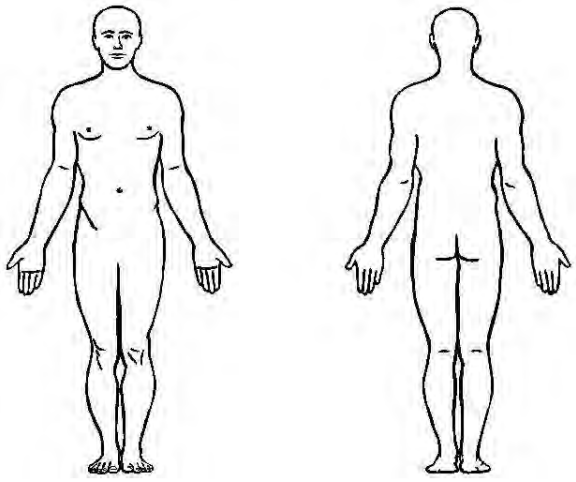
11. Previous medical intervention (Check all that apply)

☐ X-Ray ☐ MRI ☐ CATSCAN ☐ Injections ☐ Other

12. What are your goals to be achieved by the end of therapy?

13. How much time each day are you willing/able to do exercises given to you by your physical therapist?

Draw in areas of pain on body diagrams using the appropriate symbols.



OOOO -> Pins and Needles

XXXXX -> Numbness / tingling

////// -> Pain

= = = = -> Other

Medical Information (Check all that apply) **This information is confidential and remains part of your chart.

☐ Arthritis / Rheumatoid arthritis	☐ Unexplained weight loss	☐ High blood pressure	☐ Gout
☐ Heart disease / Respiratory Illness	☐ Fever / Chills / Sweats	☐ Kidney or Lung disease	☐ Stroke
☐ Blood Clots / Anemia / Hemophilia	☐ Epilepsy / Seizures	☐ Fibromyalgia	☐ HIV / Hepatitis
☐ History of Smoking (___pks/day)	☐ History of alcohol abuse	☐ History of drug abuse	☐ Pregnancy
☐ Bleeding problems / Leukemia	☐ Osteoporosis	☐ Pacemaker	☐ Asthma
☐ Depression / Anxiety	☐ Diabetes	☐ Motion sickness	☐ Cancer
☐ Metal Implants	☐ Current Infection / Fungus	☐ Hot/Cold intolerance	☐ Fatigue
☐ Temporomandibular joint pain (TMJ)	☐ Hearing loss	☐ Glaucoma	☐ Dizziness
☐ Contagious rash	☐ Breast lumps (women)	☐ Breast Surgery (women)	☐ Incontinence
☐ Poor circulation in hands or feet	☐ Thrombophlebitis	☐ Varicose veins	☐ Skin irritation
☐ Tendency to bruise	☐ Headaches	☐ Numbness	☐ Weakness
☐ Slurred speech	☐ Enlarged liver or spleen	☐ Nausea or vomiting	☐ Ulcer
☐ Crohn's Disease	☐ Replacement Therapy	☐ Hormonal imbalance	☐ Hernia
☐ Genital infection	☐ Genital surgery	☐ Musculoskeletal fracture	☐ Strain/Sprain
☐ Previous back or neck injury	Other ☐		

Do you exercise? How often? days/week, hrs/day Doing What?

MEDICATIONS:

ALLERGIES:

Submit Reset