



Name _____ Date _____ Age _____

Referring Doctor _____

Pain Diagram
Please mark your pain/symptoms on the model

Reason for seeking physical therapy: _____

When did symptoms begin: _____

What caused the symptoms to begin?
(i.e. athletic injury, fall, etc) _____

Rate your worst pain on a scale of 0-10,
10 being the worst: _____

What increases the pain _____

What decreases the pain _____

Please list any diagnostic tests performed (i.e. x-ray, MRI, CT scan)

What medications are you currently taking (for this and other conditions)

Please list any allergies _____

Are you employed? Full Time Part Time Not employed due to injury Not employed outside the home

What is your occupation? _____

Do you have difficulty completing your job tasks because of pain? What tasks?

What goals would you like to achieve through physical therapy?

Check activities that you have difficulty completing at home:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Prolonged standing | <input type="checkbox"/> Up/down stairs | <input type="checkbox"/> Recreational Activities |
| <input type="checkbox"/> Personal Care | <input type="checkbox"/> Prolonged sitting | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Reaching |
| <input type="checkbox"/> Carrying | <input type="checkbox"/> Lifting | <input type="checkbox"/> Driving | <input type="checkbox"/> Squatting |

List any past injuries, surgeries, or reasons for seeking a doctor/ physical therapists' care

Past Medical History: Have you ever been diagnosed with any of the following? (Check all that apply)

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Stroke |
- Other: _____



Do you: _____ Smoke If Yes, How much? _____

Have you recently experienced any of the following? (Check all that apply)

- | | | | | |
|---|--|-----------------------------------|--|--|
| <input type="checkbox"/> Fever/chills/sweats | <input type="checkbox"/> Unexplained Weight Change | <input type="checkbox"/> Malaise | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Bowel Dysfunction |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Night Pain | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Urinary Frequency Changes/Difficulty | <input type="checkbox"/> Sexual Dysfunction | | | <input type="checkbox"/> Dizziness/lightheadedness |