

**Patient Demographics/ Medical History**

<b>Patient Name</b>				<b>Married</b> <input type="checkbox"/>	<b>Date</b>	
				<b>Single</b> <input type="checkbox"/>		
<b>Address</b>			<b>City</b>		<b>State</b>	<b>Zip</b>
<b>Home Phone</b>			<b>Cell</b>		<b>Work</b>	
<b>Emergency Contact</b>			<b>Relation to patient</b>		<b>Phone</b>	
<b>Date of Birth</b>		<b>SSN#</b>		<b>Email</b>		
<b>Employer</b>				<b>Occupation</b>		
<b>Referring Doctor</b>					<b>Phone</b>	
<b>Primary Care Doctor</b>					<b>Phone</b>	
<b>Is this a work related injury?</b>	Y	N	<b>Is this injury due to a motor vehicle accident?</b>	Y	N	
			<b>What state did the accident occur in?</b>			
<b>When and how did this problem begin?</b>						
<b>Please list 3 things you are unable to do now because of this problem:</b>						
1.						
2.						
3.						
<b>Please rate your pain from 0-10 (0 = no pain; 10 = Emergency Room pain)</b>						
<b>Least Pain Rating</b>		<b>Occurs When?</b>				
<b>Most Pain Rating</b>		<b>Occurs When?</b>				
<b>Please check the following activities that increase your symptoms:</b>						
<input type="checkbox"/>	Sit	<input type="checkbox"/>	Stand	<input type="checkbox"/>	Rise from a chair	
<input type="checkbox"/>	Walk	<input type="checkbox"/>	Bending	<input type="checkbox"/>	Lying on side (R or L)	
<input type="checkbox"/>	Driving	<input type="checkbox"/>	Cooking	<input type="checkbox"/>	Overhead reaching	
<input type="checkbox"/>	Coughing/ sneezing	<input type="checkbox"/>	Sleeping	<input type="checkbox"/>	Rolling over in bed	
<b>Circle the phase that best completes this statement:</b>						
a) "first thing in the morning"				I feel BEST... a b c		
b) "mid day"						
c) "at the end of the day"				I feel WORST... a b c		
<b>Please check any of the following that describe your pain:</b>						
<input type="checkbox"/>	At rest	<input type="checkbox"/>	Better with activity	<input type="checkbox"/>	Worse with activity	
<input type="checkbox"/>	Constant	<input type="checkbox"/>	Occasional	<input type="checkbox"/>	Ache	
<input type="checkbox"/>	Numb	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	Sharp	
<input type="checkbox"/>	Pain stays put	<input type="checkbox"/>	Pain moves around	<input type="checkbox"/>		

**What treatments have you had for this condition? (Please include dates and whether or not the treatment helped)**

**Do you currently have any of the following?**

Dizziness	Y	N	Night Pain	Y	N
Bowel or bladder control problems	Y	N	Pregnancy	Y	N
Lack of coordination with walking	Y	N	Malaise	Y	N
Unexplained weight loss or gain	Y	N	Weakness	Y	N
Numbness or tingling in one or more extremities	Y	N	Ringling in ears	Y	N
Numbness on inner thighs or groin area	Y	N	Vision Problems	Y	N
Pain with cough or sneeze	Y	N	Hearing Problems	Y	N
Tendency to Bleed or Bruise Easily	Y	N	Nausea/ Vomiting	Y	N
Sexual dysfunction or Pelvic pain	Y	N	Fever/ Sweat/ Chills	Y	N
Metal Implants (Joint Replacement)	Y	N	Latex Sensitivity or Allergy	Y	N

**If you answered yes to any of the above, please describe:**

**Have you ever had any of the following?**

Asthma	Y	N	Heart Attack	Y	N	Head Injury	Y	N
Allergies	Y	N	Pacemaker	Y	N	Osteoporosis	Y	N
Chronic Bronchitis	Y	N	Thyroid Problems	Y	N	Osteopenia	Y	N
Emphysema	Y	N	Diabetes	Y	N	Parkinson's	Y	N
Lung Problems	Y	N	Muscular Dystrophy	Y	N	Stroke/ TIA	Y	N
Kidney Problems	Y	N	Multiple Sclerosis	Y	N	Depression	Y	N
On Dialysis	Y	N	Tuberculosis	Y	N	Chemical dependency	Y	N
Heart Disease	Y	N	Back/ Neck Problems	Y	N	Degenerative Arthritis	Y	N
High Blood Pressure	Y	N	Cancer	Y	N	Rheumatoid Arthritis	Y	N
Anemia	Y	N	Seizures	Y	N	Arthritic Conditions	Y	N

**If you answered yes to any of the above, please describe:**

**Recent surgeries or hospitalizations in the past 12 months?**

**Please list all medications you are taking. Please include any steroids or anticoagulants you take.**

**What are your goals or expectations for therapy?**

**Are you currently receiving therapy or treatment of any kind?**

## Modified Pain Disability Index

**Patient name:** \_\_\_\_\_

This survey is designed to measure the degree to which your life is disrupted by your condition. Respond to each of the 10 categories by indicating the overall impact that pain, weakness and/or mobility impairments are having in your life. Use the 0 to 10 point scale below to describe the level of disability you typically experience. A score of 0 means no disability at all and a score of 10 signifies the activities are completely disrupted or prevented by your condition.

Assessment **A**: Complete column A at your initial PT evaluation      Date: \_\_\_\_\_  
 Assessment **B**: Complete column B at your final PT session      Date: \_\_\_\_\_  
 Assessment **C**: Complete column C three months after your discharge from PT      Date: \_\_\_\_\_

“I feel great”      0      1      2      3      4      5      6      7      8      9      10      “I feel horrible”

		Assessment	A	B	C
1	<b><u>Pain Scale:</u></b> Please rate your pain due to this condition.				
2	<b><u>Family/home responsibilities:</u></b> This category refers to activities of the home or family. It includes chores or duties performed around the house (cleaning, yard work, etc) and errands or favors for other family members (driving the children to school, shopping, etc).				
3	<b><u>Recreation:</u></b> This category includes hobbies, sports, and other similar leisure time activities.				
4	<b><u>Social activity:</u></b> This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.				
5	<b><u>Sexual behavior:</u></b> This category refers to the frequency and quality of one's sex life.				
6	<b><u>Self care activities:</u></b> This category refers to basic self care tasks such as eating, sleeping, bathing & dressing.				
7	<b><u>Occupation:</u></b> This category refers to activities that are a part of or directly related to one's job. It includes non-paying jobs such as homemaker or volunteer worker.				
8	<b><u>Self-management:</u></b> This category asks you to rate your confidence in your ability to effectively control or eliminate your pain with independent self-management strategies.				
9	<b><u>Prevention strategies:</u></b> This category asks you to rate your confidence in your ability to independently prevent future episodes of this condition.				
10	<b><u>Expectations for symptom free living:</u></b> This category asks you to rate the extent of improvement you feel is possible, based on your condition, with physical therapy treatments and a prescribed home program.				