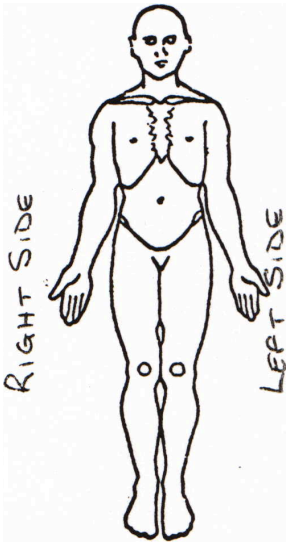
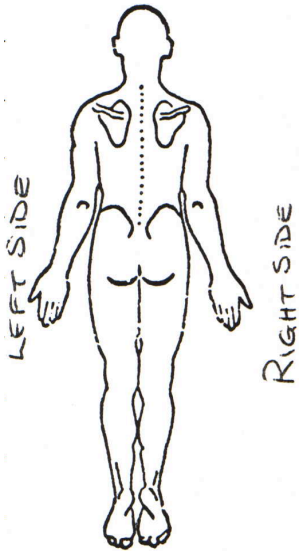
PAIN/HISTORY FORM

Mark your area of most significant pain





Do you have any history of orthopaedic injury or surgery? _____ If yes, please explain

_____

Have you had Physical/Occupational/Podiatric Therapy or Home Health before? _____

If so, when? _____ to _____ Your insurance may not cover you if you are still treating elsewhere

Do you have: Heart disease? _____ High Blood Pressure? _____ Diabetes? _____

Neurological problems? _____ Cancer? _____ Pacemaker? _____ Pregnant? _____

Briefly describe how and when your pain began: (example Tripped over curb on 2/12/2003)

_____

Is your pain: Constant? _____ Comes and goes _____ Occasional: _____

When is your pain the worst? _____

What do you do to relieve the pain? _____

Describe your pain: Sharp _____ Dull _____ Achy _____ Shooting _____

Pain Medications _____ **Allergies to medicine?** _____

Does your pain wake you up at night? _____ **Are you working?** _____

Estimate the pain you are experiencing during normal activities:

0 ----- 1 ----- 2 ----- 3 ------ 4 ----- 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10
No Pain Unbearable

100% ---- 90% ---- 80% ---- 70% ----- 60% ---- 50% ----- 40% ----- 30% ----- 20% ----- 10% -----0%
Everyday functionality

_____ _____
Patient's Signature Date

Revised 9/10/09