**BODY ZONE™**
**PHYSICAL THERAPY**

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# 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 ☐ 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/makes your condition worse? (Check all that apply)

| | | | |
|---|---|---|---|
| ☐ Bending | ☐ Movement | ☐ Rest | ☐ Sneeze |
| ☐ Standing | ☐ Stairs | ☐ Deep breath rising | ☐ Sitting |
| ☐ Walking | ☐ Cough | ☐ Medication | ☐ Prolonged |
| ☐ 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 the apply)

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

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

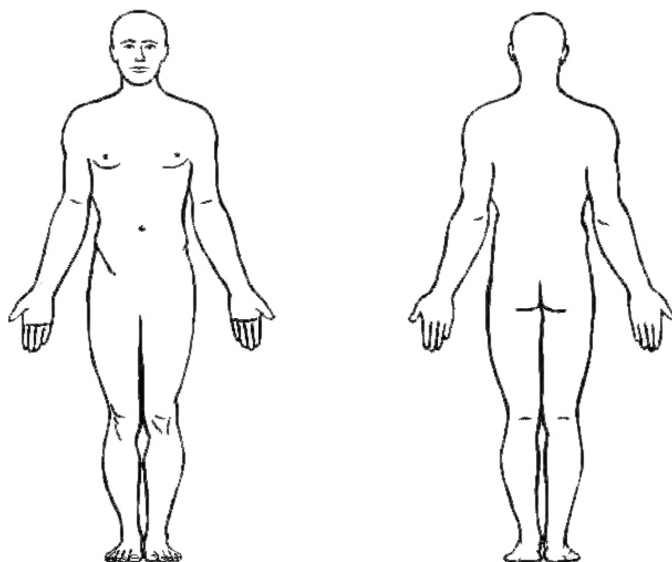
______________________________

______________________________

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

XXXX → Numbness/Tingling

/ / / / / → Pain

= = = = → Other

**MEDICAL INFORMATION (CHECK ALL THAT APPLY)**

***This information is confidential and remains part of your chart.*

- ☐ Arthritis / Rheumatoid Arthritis
- ☐ Heart Disease / Respiratory Illness
- ☐ Blood Clots / Anemia / Hemophilia
- ☐ History of Smoking (_____ Packs/Day)
- ☐ Bleeding Problems / Leukemia
- ☐ Depression / Anxiety
- ☐ Metal Implants
- ☐ Temporomandibular Joint Pain (TMJ)
- ☐ Contagious Rash
- ☐ Poor Circulation in Hands or Feet
- ☐ Tendency to Bruise
- ☐ Slurred Speech
- ☐ Crohn's Disease
- ☐ Genital Infection
- ☐ Previous Back or Neck Injury
- ☐ Unexplained Weight Loss
- ☐ Fever / Chills / Sweats
- ☐ Epilepsy / Seizures
- ☐ History of Alcohol Abuse
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Current Infection / Fungus
- ☐ Hearing Loss
- ☐ Breast Lumps (Women)
- ☐ Thrombophlebitis
- ☐ Headaches
- ☐ Enlarged Liver or Spleen
- ☐ Replacement Therapy
- ☐ Genital Surgery
- ☐ Other ______________________________________________
- ☐ High Blood Pressure
- ☐ Kidney or Lung Disease
- ☐ Fibromyalgia
- ☐ History of Drug Abuse
- ☐ Pacemaker
- ☐ Motion Sickness
- ☐ Hot/Cold Intolerance
- ☐ Glaucoma
- ☐ Breast Surgery (Women)
- ☐ Varicose Veins
- ☐ Numbness
- ☐ Nausea or Vomiting
- ☐ Hormonal Imbalance
- ☐ Musculoskeletal Fracture
- ☐ Gout
- ☐ Stroke
- ☐ HIV / Hepatitis
- ☐ Pregnancy
- ☐ Asthma
- ☐ Cancer
- ☐ Fatigue
- ☐ Dizziness
- ☐ Incontinence
- ☐ Skin Irritation
- ☐ Weakness
- ☐ Ulcer
- ☐ Hernia
- ☐ Strain / Sprain

Do you exercise? ☐ YES ☐ NO How often? __________ Days/Week __________ Hours/Day

Doing what? ______________________________________________

MEDICATIONS: ______________________________________________

______________________________________________

ALLERGIES: ______________________________________________

______________________________________________