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. Has your condition been getting: ☐ Worse ☐ Same ☐ Better
6. 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) |

7. Previous medical intervention (Check all the apply)

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

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

## 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 | ☐ Stroke |
| ☐ Heart Disease / Respiratory Illness | ☐ Fever / Chills / Sweats | ☐ Kidney or Lung Disease | ☐ HIV / Hepatitis |
| ☐ Blood Clots / Anemia / Hemophilia | ☐ Epilepsy / Seizures | ☐ Fibromyalgia | ☐ Pregnancy |
| ☐ History of Smoking (_____ Packs/Day) | ☐ History of Alcohol Abuse | ☐ Musculoskeletal Fracture | ☐ Asthma |
| ☐ Bleeding Problems / Leukemia | ☐ Osteoporosis | ☐ Glaucoma | ☐ Cancer |
| ☐ Depression / Anxiety | ☐ Diabetes | ☐ Numbness | ☐ Fatigue |
| ☐ Metal Implants | ☐ Current Infection / Fungus | ☐ Strain / Sprain | ☐ Dizziness |
| ☐ Temporomandibular Joint Pain (TMJ) | ☐ Hearing Loss | ☐ Tendency to Bruise | ☐ Incontinence |
| ☐ Contagious Rash | ☐ Pacemaker | ☐ Slurred Speech | ☐ Skin Irritation |
| ☐ Poor Circulation in Hands or Feet | ☐ Thrombophlebitis | ☐ Replacement Therapy | ☐ Weakness |
| ☐ Crohn's Disease | ☐ Headaches | | |
| ☐ Previous Back or Neck Injury | ☐ Enlarged Liver or Spleen | ☐ Other ____________ | |

MEDICATIONS: ______________________________

ALLERGIES: ______________________________