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 home health care? ☐ Yes ☐ No Discharged Date: _____
6. Has your condition been getting: ☐ Worse ☐ Same ☐ Better
7. 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)

8. Previous medical intervention (Check all the apply)

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

9. 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	☐ Kidney or Lung Disease	☐ HIV / Hepatitis	☐ Pregnancy
☐ Blood Clots / Anemia / Hemophilia	☐ Epilepsy / Seizures	☐ Fibromyalgia	☐ Cancer
☐ History of Smoking (_____ Packs/Day)	☐ Musculoskeletal Fracture	☐ Asthma	☐ Dizziness
☐ Bleeding Problems / Leukemia	☐ Previous Back or Neck Injury	☐ Osteoporosis	☐ Fatigue
☐ Depression / Anxiety	☐ Diabetes	☐ Numbness	☐ Weakness
☐ Metal Implants	☐ Incontinence	☐ Pacemaker	☐ Headaches
☐ Poor Circulation in Hands or Feet	☐ Tendency to Bruise	☐ Contagious Rash	

☐ Other _____

MEDICATIONS: _____

ALLERGIES: _____