

# WEST END

R e h a b

## Physical Therapy

### HISTORY OF CURRENT CONDITION

NAME:

TODAYS DATE:

Why are you coming to Physical Therapy?

Auto accident

On-the-job injury

Post surgical rehab

Other

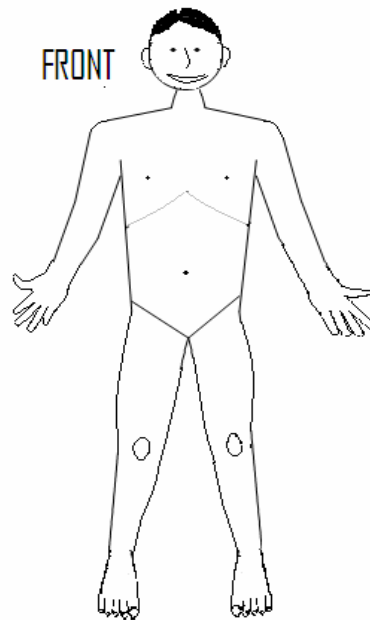
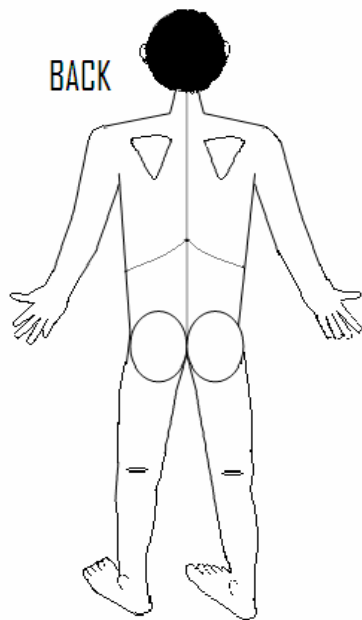
When did this problem begin?

Explain your condition Please include how it happened and previous treatment for this condition

1.

### Where is your pain?

Please mark on the drawing below the area where you feel pain. Place an 'X' in the place(s) where you feel the pain the most, and indicate by shading where the pain spreads to other parts of your body. You can be as descriptive as you like.



**2. a) What types of things relieve your pain?**

(e.g. medication, activities, posture, ...)

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**b) What types of things worsen your pain?**

(e.g. your job, house work, walking, ...)

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**3. Do you have any of the following?**

(Circle those that apply)

a. Numbness?      [Yes] [No]    If [Yes], where? \_\_\_\_\_

b. Tingling?        [Yes] [No]    If [Yes], where? \_\_\_\_\_






c. Weakness?       [Yes] [No]    If [Yes], where? \_\_\_\_\_

d. Incontinence?   [Yes] [No]    If [Yes], does it affect your  Bowel  Bladder or  Both \_\_\_\_\_

Do you have severe pain at night which markedly disturbs your sleep?      [Yes] [No]

**4. Activities**

Please X the appropriate box for how much pain you experienced in the last 24 hours while performing each of the following activities.

Can you perform these activities?	YES no problems 	YES with mild Pain 	YES with severe Pain 	YES but only with help 	NO I cannot do this 
Putting on shoes and socks					
Dressing					
Bathing or Shower					
Comb hair					
Stand up from a low chair					
Stand up from the floor					
Stairs (1 flight)					

5. Non-lifting Tasks							
How long are you able to perform each of these tasks? (you may estimate)	I cannot do this	Less than 5 minutes	5 – 15 minutes	15 – 30 minutes	30 – 60 minutes	1 – 2 hours	No Limitation
Standing							
Walking							
Sitting							
Sleeping							
Driving a car / riding in a car							
keyboarding							
Writing							
Reading							
Grasping / pinching							
Reaching overhead							
Stooping over a sink							

6. Lifting Ability (you may estimate)						
	I cannot do this	Less than 5 pounds	5 – 10 pounds	10 - 20 pounds	20 - 50 pounds	50+ pounds
From floor to waist level						
From waist to chest level						
From waist to overhead						

7. How strong is your pain? (please mark an 'X' on the lines below)		
How strong is your pain <b>now</b> ?	How strong is your pain at it's <b>best</b> ?	How strong is your pain at it's <b>worst</b> ?
<i>worst pain imaginable</i>	<i>worst pain imaginable</i>	<i>worst pain</i>
10  —	10  —	10  —
9  —	9  —	9  —
8  —	8  —	8  —
7  —	7  —	7  —
6  —	6  —	6  —
5  —	5  —	5  —
4  —	4  —	4  —
3  —	3  —	3  —
2  —	2  —	2  —
1  —	1  —	1  —
0  —	0  —	0  —
<i>No pain at all</i>	<i>No pain at all</i>	<i>No pain at all</i>

8. Are you working at the present? [Yes] [No]
If you answered <u>No</u> , please complete these questions
When did you last have full time employment? _____
What is (was) your job? _____
Please describe what physical activities are involved? _____
Was it your present pain that stopped you working? [Yes] [No]

9. Is there anything else you would like to say that may help us to understand your condition?
_____
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