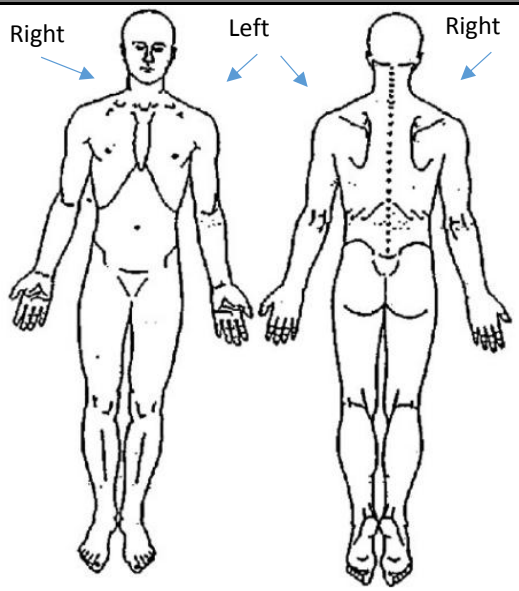
Pain Questionnaire

Name:

Pain Levels	No Pain	Mild			Moderate			Severe			Emergency
Today	0	1	2	3	4	5	6	7	8	9	10
Good Day	0	1	2	3	4	5	6	7	8	9	10
Bad Day	0	1	2	3	4	5	6	7	8	9	10

Pain Duration	☐Comes & Goes		☐Ocassional	☐Frequent	☐Constant
Symptoms	☐Forgotten During Activities ☐Interfere With Activities ☐Worse With Activities ☐Prevents Activities				
Improvements	☐Getting Better ☐ Getting Worse ☐ Staying the Same ☐ No Improvement With Therapy				

What Makes Your Symptoms Worse	Current Symptoms	Please Mark All Areas That Are Painful	What Makes Your Symptoms Better
❑ Work Activities ❑ Home Activities ❑ Personal Hygiene ❑ Sitting ❑ Standing ❑ Walking ❑ Reaching ❑ Grasping ❑ Bending ❑ Lifting ❑ Pushing ❑ Pulling ❑ Twisting ❑ Squatting ❑ Kneeling ❑ Climbing Stairs ❑ Coughing ❑ Sneezing ❑ Bowel Problems ❑ Bladder Problems	❑ Dull ❑ Achy ❑ Stiff ❑ Tight ❑ Itching ❑ Heavy ❑ Gnawing ❑ Cramping ❑ Swollen ❑ Burning ❑ Throbbing ❑ Numbness ❑ Tingling ❑ Stretching ❑ Pinching ❑ Grinding ❑ Sharp ❑ Stabbing ❑ Shooting ❑ Radiating		❑ Rest Brakes ❑ Ice Pack ❑ Compression ❑ Elevation ❑ Avoiding Activities ❑ Alternating Positions ❑ Heat Pack/Shower ❑ Electric Stimulation ❑ Splint ❑ Sling ❑ Crutches/Cane ❑ Home Massage ❑ Home Exercise ❑ Stretching ❑ Walking ❑ Movement **Medications:** ❑ Pain Killers ❑ Anti-inflamatory ❑ Muscle Relaxer ❑ Anti-Depressant

Name of Medications:	
Currently Working	❑ Yes ❑ No Reason for Not Returning to Work:

Additional Information

Signature: **Date:**

Accident Injury Report

Name:	**Title:**	**Years:**	**Today's Date:**
Empoyer:	**Required PDC:**	**Date of Injury:**	
Diagnosis:			

Current Work Status

Working?	☐Full Time ☐Part Time ☐Light Duty ☐Full Duty ☐Restrictions ☐No Restrictions
Not Working?	☐No Light Duty ☐Laid Off ☐Fired ☐ Quit ☐ Retired ☐Different Job

Mechanism of Injury: How Did This Injury Occur?

What Activitis Were You Performing?	
Body Position, Bending, Lifting, Twisting, Reaching	
Weight Lifted, Distance, Repetitions, Duration	
Type of Accident: Slip, Trip, Fall	
Distance of Fall, Surface, Position	
Vector / Forces Involved	
Body Areas Injured	
Onset of Pain: Sudden, Gradual	
Anatomical Location of Pain	
Localized or Diffuse Pain	
Type of Initial Pain: Mild, Moderate, Severe	
Description of Pain: Sharp, Dull, Achy	
Assisted Needed to Get Up?	❑ Yes ❑ No
Was an Ambulance Called?	❑ Yes ❑ No
Did You Go to a Hospital?	❑ Yes ❑ No
X-Ray, CT, MRI Ordered?	❑ Yes ❑ No
Treated and Released?	❑ Yes ❑ No
Did You Go Back to Work?	❑ Yes ❑ No
Did You Go Home?	❑ Yes ❑ No
When Therapy Started?	

Reason For Not Returning To Work At Some/Any Capacity

Signature: **Date:** **Evaluator's Initials:**

Intake Form

Patient Information

Name:	Date of Birth:	SS#:	Fecha:
Employer:	Job Title:	Years:	Date of Injury:
Age:	Sex:	Ht:	Wt:

Do You Currently Have Any of the following Health Issues?

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Respiratory Disease
- ❑ Pressure or Tightness in the Chest
- ❑ Irregular Heart Beat of Palpitations
- ❑ Shortness of Breath or Difficulty Breathing
- ❑ Dizziness, Loss of Balance
- ❑ Abdominal or Inguinal Hernia
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Thyroid Disorder
- ❑ Chronic Obstructive Pulmonary Disease
- ❑ AIDS
- ❑ Hepatitis A B C
- ❑ Stroke or TIA
- ❑ Clinical Depression
- ❑ Change in Color or Urine or Stool
- ❑ Other:

Current Medications

- ❑ List Medications Heres:
- ❑ Can't Remember

Prior Injuries or Complaints

Were you able to perform the essential functions of your job without pain or restrictions?	☐ Yes ☐No
Any prior work, sports or other injuries to the same area prior to this accident?	☐ Yes ☐No
Did you have any restrictions in your personal, social activities prior to this injury?	☐ Yes ☐No
Have you missed work days due to pain in these areas prior to this injury?	☐ Yes ☐No

Treatment Received

Services Received	Date Completed	Total Sessions	Outcomes
Surgery			☐Good ☐Fair ☐Poor ☐No Change
Epidural Steroid Injections			☐Good ☐Fair ☐Poor ☐No Change
PT/OT Sessions			☐Good ☐Fair ☐Poor ☐No Change
Chiropractic Sessions			☐Good ☐Fair ☐Poor ☐No Change
Acupunture Treatment			☐Good ☐Fair ☐Poor ☐No Change
Work Conditioning			☐Good ☐Fair ☐Poor ☐No Change
Chronic Pain Management			☐Good ☐Fair ☐Poor ☐No Change

Additional Service Planned

Date of Last Doctor's Appt:		Treatment Scheduled?	☐Yes ☐No Date:
Date of Last Physical Therapy Session:		Surgery Scheduled?	☐Yes ☐No Date:
Consultation Scheduled ☐Yes ☐No Date:		Discharged From Care?	☐Yes ☐No Date:

Signature: **Date:** **Evaluator's Initials:**