RIVER PARISH
Physical Therapy & Wellness

PATIENT HISTORY

Name: _____ Date: _____

D.O.B. _____ Occupation: _____

Date of injury or onset of complaint(s):_____

_____

Briefly describe how you were injured or how complaints began (i.e. after tennis, bending....):

_____

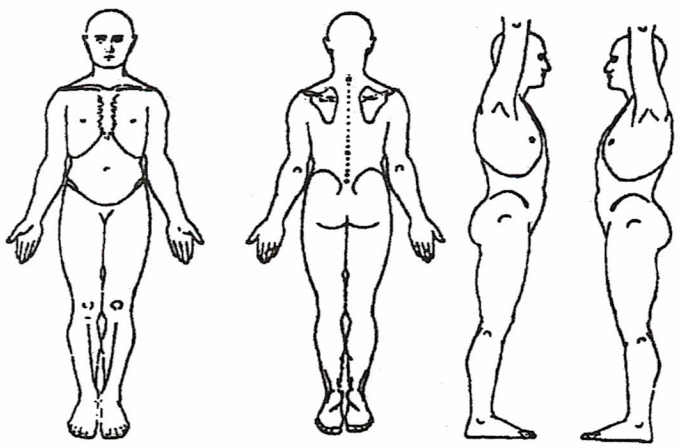
_____

Have you fallen recently? YES NO If Yes, how many times this year _____.
How did you fall_____
Did you injured yourself during the fall? _____

Please completely fill out the following questions:
Where is your pain / injury located?

_____

Please use the drawings to indicate the location of your pain/injury.



0-10 VAS Numeric Pain Distress Scale

No pain — Moderate pain — Unbearable pain

0 1 2 3 4 5 6 7 8 9 10

PAIN LEVELS:
CURRENT _____
WORST _____
BEST _____

Circle the following that best describe the pain:

Aching	Sharp
Cramping	Shooting
Fearful	Tender
Gnawing	Throbbing
Heavy	Tingling
Hot or burning	

Have you had any treatment for this condition? Yes ___ No____
If yes, When _____

How often do you experience your symptoms?
____Constantly (76-100% of the day): _____Occasionally (26-50% of the day)
____Frequently (51-75% of the day : _____Intermittently (0-25% of the day)

What makes your symptoms better? (Ex. Rest, medication) _____

_____

What makes your symptoms worse? (Ex. Lifting, sitting, bending, stairs, squatting, kneeling) _____

_____