McDonough
PHYSICAL THERAPY

General Health Information

Patient Name: ________________________ DOB: ___/___/____ Diagnosis or Problem Area: __________________

Date of injury/onset of symptoms: __________________ **OR** Date of Surgery: ______________________________

Type of Surgery: ____

If not from surgery, briefly describe how symptoms started: ____

____

What aggravates your injury / problem area? ____

What relieves your injury / problem area? ____

Pain Diagram: Use symbols below to mark diagram

Description:

^^^ = Aching
/// = Numbness
>>> = Stabbing
xxx = Burning
000 = Pins / Needles
+++ = Throbbing

Is the pain getting:

□Better □Worse □No Change

List your medications:

____
____
____
____
____
____
____
____
____
____

Please check as many of the following conditions that apply to you. Are you currently or have you ever experienced the following:

□ Alzheimer's	□ Cardiovascular Disease	□ Cauda Equina Syndrome
□ Cerebral Vascular Accident (Stroke)	□ Current Infection	□ Diabetes Mellitus Type 1
□ Diabetes Mellitus Type 2	□ Fibromyalgia	□ Fracture of Suspected Fracture
□ High Blood Pressure	□ History of Cancer	□ Huntington's Disease
□ Immunosuppression	□ Incontinence	□ Lupus
□Major Motor Weakness	□ Muscular Dystrophy	□ Obesity
□Osteoarthritis	□ Parkinson's	□ Rheumatoid Arthritis
□ Recent Onset Bladder Dysfunction	□ Saddle Anesthesia	□ Traumatic Brain Injury

Rate your pain from 0-10 as follows:

0-1 No Pain	4-5 Moderate / Discomforting	8-9 Intense / Very Severe Pain
2-3 Mild Pain	6-7 Distressing / Severe Pain	10 Severe / Unbearable Pain

Now: ______ **At its Best:** _____ **At its Worst:** _____

______________________________ ______________________________ ________________

Patient Signature **Parent / Guardian Signature** **Date**