McDonough
PHYSICAL THERAPY

General Health Information

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

Describe how you injured yourself. If not from an injury, describe when and in what part of your body the pain or dysfunction started. ____

____

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:

____
____
____
____
____
____
____
____
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____

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

□Chest Pain
□Heart Attack
□High Blood Pressure
□Low Blood Pressure
□High Blood Cholesterol (Hyperlipidemia)
□Imbalance / Frequent Falls
□Bleeding / Bruising Problem
□Blood Clots
□Respiratory Disease
□Difficulty Breathing / Shortness of Breath
□Head Injury

□Stroke
□Seizures
□Blackouts
□Arteriosclerosis
□Dizziness
□Poor Circulation
□Cancer
□Severe Night Pain
□Night Sweats
□Osteoporosis
□Diabetes

□Numbness to Hands or Feet
□Visual / Hearing Problems
□Osteoarthritis
□Tuberculosis
□Rheumatoid Arthritis
□Skin Rash / Disease
□HIV / AIDS
□Hepatitis
□Smoking
□Pregnancy
□Bowel / Bladder Problems

Rate your pain from 0-10 as follows:

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

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

________________________________ ________________________________ _________________

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

Describe the problems or limitations you are having now.____

____

What activities aggravate your injury / problem area? ____

What activities relieve your injury / problem area? ____