WOMEN'S CHOICE PHYSICAL THERAPY, LLC

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NAME:________________________ **DATE:**________________________
AGE:________________________ **DOCTOR:**________________________
CURRENT MEDICATIONS:____

GENERAL MEDICAL HYSTORY: Check all that apply

X	**GENERAL**	X	**PAIN**	X	**Prostate**	X	**SURGERIES**
	Anxiety		Arm		High PSA		Heart
	Arthritis		Shoulder		Biopsy		Orthopedic
	(Rheumatoid)		Chest/breast		Chronic inflammation		Cancer
	Depression		Neck				Abdominal
	Diabetes		Back		vasectomy		Other:
	Dizziness		Abdomen				
	Fibromyalgia		Pelvis				
	Heart Disease		Hip				
	High blood press.		Knees		**Please list any**		
	Kidney disease		Ankle/foot		**Other relevant**		
	Liver disease		Other:		**Medical history:**		
	Lung disease		No Pains				
	Multiple Sclerosis		**BOWEL & BLADDER**				
	Muscle/Tendon		Leaking urine				
	Orthopedic		IBS				
	Osteoporosis		Constipation				
	Pacemaker		Diarrhea				
	Parkinson's		Bladder surgery				
	Physical/Sex abuse						
	Skin Disorder						
	Stroke						

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Please describe your primary problem:______________________________

When/How did it occur:______________________________

Please list any tests you have had to evaluate your primary problem:________________

Is it getting: better worse staying the same varied (circle one)

What helps your primary problem/pain? (mark all that apply)

() medication () pain medication () heat () ice () massage
() lying down () relaxation () bath () music () meditation
() injections () empty bladder () bowel movement () nothing
() other____________________

What makes your primary problem/pain worse? (mark all that apply)

() sitting () standing () walking () exercise () intercourse
() full bladder () bowel movement () stress () time of day () urination
()not sure () other____________________________

Social History: Please check appropriate circle

() single () married () widowed () separated () divorced () committed relationship
working? () yes () no If yes, what kind of work?__________________
disabled? () yes () no

Pain History: Please mark below your average daily pain

|____|
No pain Worst pain imaginable

Please circle all words that describe your pain

ache sharp shooting stabbing cramping burning hot
deep tender heavy tiring sickening cramping superficial
other:____________________

What activities are you unable to do or limited in because of your pain/problem?

Anything else you would like us to know?______________________________

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On the diagram, shade in <u>all</u> the areas where you feel pain. If there is an area that hurts more than anywhere else, put an X on that area.