

MEDICAL HISTORY/PAIN CHART AND ADL SCREEN

PATIENT: _____ AGE: _____

Are you on any medications? YES NO Please list all prescription, over the counter and herbal medicines below as well as dosage, frequency and route of administration i. e. oral or injected

Height: ____ft ____ inches Weight: _____ lbs.

2 or more falls in the past year? ___ Y ___N Any fall in the last year resulting in injury ___Y ___N

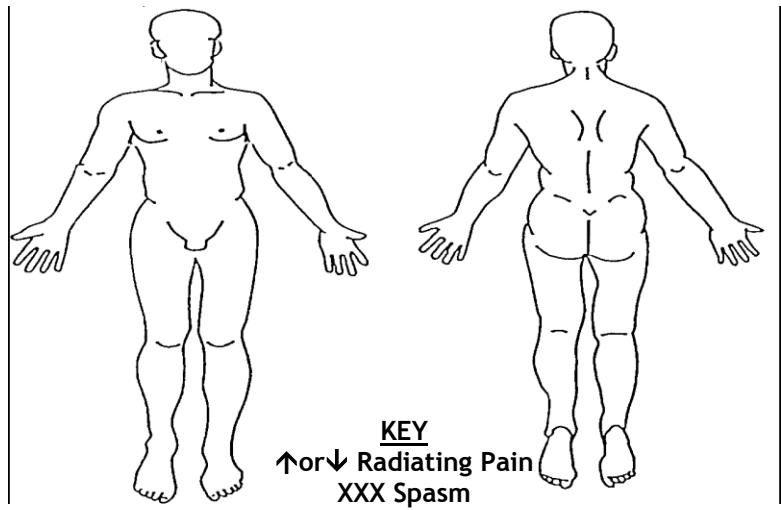
Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Headaches	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Dizzy Spells	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fainting Spells	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Epilepsy	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Stroke	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you currently pregnant	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Asthma	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Emphysema	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Osteoporosis/Osteopenia	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Back injury	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Arthritis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bleeding disorder	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fracture	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cancer	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Pacemaker	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Metallogy (implants)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Respiratory problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Tuberculosis	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hepatitis A,B,C	<input type="checkbox"/> YES	<input type="checkbox"/> NO
MRSA	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HIV/AIDS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Heart Trouble	<input type="checkbox"/> YES	<input type="checkbox"/> NO
High Blood Pressure	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bowel/bladder problems	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sudden weight loss	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Allergies	<input type="checkbox"/> YES	<input type="checkbox"/> NO
List:		

Please circle all that may apply. My pain is worse:
In the morning/during the day/at night/constantly/
with activity/during rest.

On a scale of 0 to 10,
0 being no pain and 10 being unbearable pain requiring hospitalization,
rate your pain at its best _____ and worst _____.

Using the key provided, draw the symbol representing your pain over the area of the body as it relates to your present condition.



KEY
 ↑or↓ Radiating Pain
 XXX Spasm
 ZZZ Tenderness
 ///// Numbness/Tingling
 0000 Ache/Pain

As it relates to your current problem, are you unable to or have difficulty with performing any of the following activities? Do you have pain associated with or have you changed your method of performing any of the following tasks? **Check all that apply?**

- | | | | | |
|---|--|-----------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> Getting in/out of bed | <input type="checkbox"/> Personal hygiene activities | <input type="checkbox"/> Eating | <input type="checkbox"/> Shaving | <input type="checkbox"/> Cleaning |
| <input type="checkbox"/> Getting in/out of car | <input type="checkbox"/> Bathing/shower | <input type="checkbox"/> Sleeping | <input type="checkbox"/> Lifting | <input type="checkbox"/> Writing |
| <input type="checkbox"/> Getting in/out of chair | <input type="checkbox"/> Brushing teeth | <input type="checkbox"/> Sitting | <input type="checkbox"/> Cooking | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Walking up/down stairs | <input type="checkbox"/> Dressing | <input type="checkbox"/> Standing | <input type="checkbox"/> Laundry | <input type="checkbox"/> Driving |
| <input type="checkbox"/> Getting in/out of shower | <input type="checkbox"/> Work activities | <input type="checkbox"/> Walking | <input type="checkbox"/> Vacuuming | |
| <input type="checkbox"/> Other _____ | | | | |

✍ Patient Signature: _____ Date: _____