



BARROWS

TRAINING AND EDUCATION
PHYSICAL THERAPY

Where excellence and experience make a difference in your care.

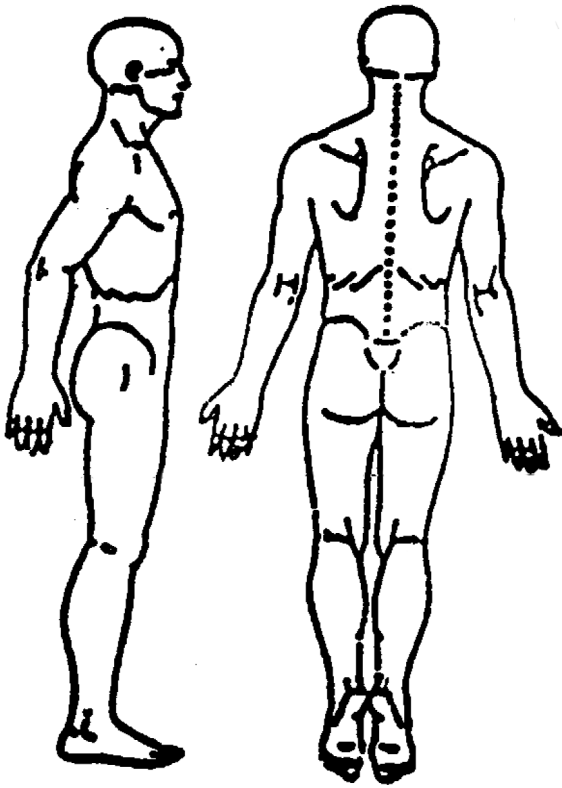
PAIN AND INJURY

(Please Print)

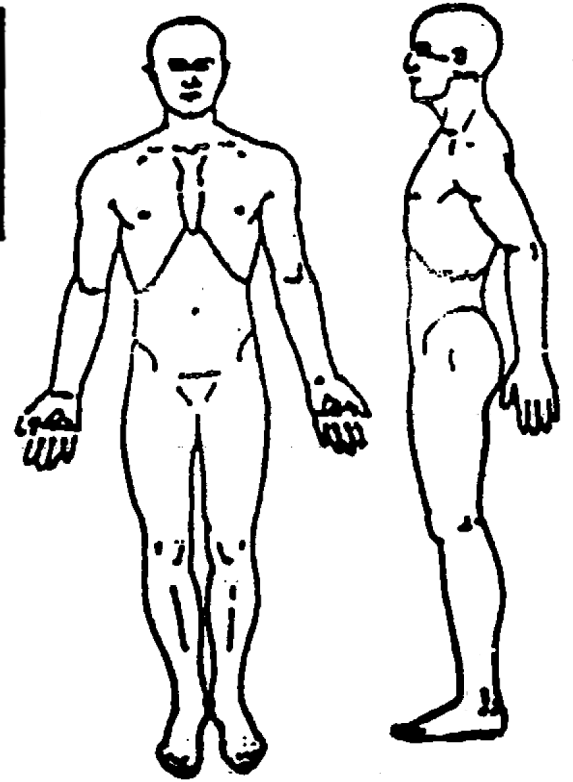
PATIENT INFORMATION					
Patient's Last Name:	First:	Middle:	Age:	Dominant Hand:	Sex:
				<input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> M <input type="checkbox"/> F
Employer:		Occupation:			
INJURY INFORMATION					
What body part(s) were initially injured?					
1.			2.		
3.			4.		
Describe how the injury happened:					
Did you have surgery for this condition?			<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please indicate:					
Date: _____	Body Part:	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Knee	<input type="checkbox"/> Ankle	<input type="checkbox"/> Neck <input type="checkbox"/> Other: _____
What body parts are currently painful?					
1.			2.		
3.			4.		
Your symptoms began:			<input type="checkbox"/> Immediately <input type="checkbox"/> Gradually		
Since the injury/condition began your symptoms are:			<input type="checkbox"/> Increasing <input type="checkbox"/> Decreasing <input type="checkbox"/> Not changing		
How much of the day do you feel your symptoms?			<input type="checkbox"/> Occasional (10 – 25%) <input type="checkbox"/> Intermittent (26 – 50%) <input type="checkbox"/> Frequent (51 – 80%) <input type="checkbox"/> Constant (80 – 100%)		
Choose below what most accurately describes your symptoms:					
<input type="checkbox"/> Pain is annoying but able to perform all activities					
<input type="checkbox"/> Pain is tolerated but may cause difficulty performing some activities					
<input type="checkbox"/> Pain interferes with performance of all activities					
<input type="checkbox"/> Pain is so severe that you are unable to perform any activity					

Sleep:	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Position:	<input type="checkbox"/> Back	<input type="checkbox"/> Side	<input type="checkbox"/> Stomach
Symptoms are <u>best</u>:	(Time of day)	<input type="checkbox"/> A.M.	<input type="checkbox"/> P.M.	<input type="checkbox"/> Sit	<input type="checkbox"/> Stand	<input type="checkbox"/> Walk	
Symptoms are <u>worst</u>:	(Time of day)	<input type="checkbox"/> A.M.	<input type="checkbox"/> P.M.	<input type="checkbox"/> Sit	<input type="checkbox"/> Stand	<input type="checkbox"/> Walk	
What makes your injury/condition feel better or worse? Use "○" for better, "X" for worse							
<input type="checkbox"/> Nothing	<input type="checkbox"/> Sitting	<input type="checkbox"/> Standing	<input type="checkbox"/> Walking	<input type="checkbox"/> Running	<input type="checkbox"/> Stairs		
<input type="checkbox"/> Rest	<input type="checkbox"/> Movement	<input type="checkbox"/> Exercise	<input type="checkbox"/> Stretching	<input type="checkbox"/> Medication	<input type="checkbox"/> Lying Down		
<input type="checkbox"/> Kneeling	<input type="checkbox"/> Bending	<input type="checkbox"/> Twisting	<input type="checkbox"/> Lifting	<input type="checkbox"/> Writing	<input type="checkbox"/> Keying		
<input type="checkbox"/> Repetitive hand motion	<input type="checkbox"/> Coughing	<input type="checkbox"/> Sneezing					
<input type="checkbox"/> Others not listed above: _____							
What treatments have you already received for this condition?							
<input type="checkbox"/> Physical Therapy: _____				<input type="checkbox"/> None			
<input type="checkbox"/> Chiropractic: _____				<input type="checkbox"/> Surgery: _____			
Diagnostic Tests: <input type="checkbox"/> CT Scan: _____				<input type="checkbox"/> Other: _____			
<input type="checkbox"/> MRI: _____				<input type="checkbox"/> EMG / NCV: _____			
Name of facility: _____				<input type="checkbox"/> X-Ray: _____			
				Date: _____			
What medications are you taking for this condition?							
1.					x day	<input type="checkbox"/> A.M.	<input type="checkbox"/> P.M.
2.					x day	<input type="checkbox"/> A.M.	<input type="checkbox"/> P.M.
3.					x day	<input type="checkbox"/> A.M.	<input type="checkbox"/> P.M.
General health:							
<input type="checkbox"/> Good		<input type="checkbox"/> Diabetes		<input type="checkbox"/> High blood pressure			
What medications are you taking for <u>other</u> conditions?							
1.	_____	2.	_____				
3.	_____	4.	_____				
Hobbies / Activities:							
Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, last date worked: _____							
Do you have any work limitations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list limitations: _____							
Have you had any previous work-related injuries other than the current one? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, what body part and when? (Please describe)							

MARK ON THE PICTURE WHERE YOU HAVE PAIN OR SYMPTOMS



//	=	NUMBNESS
..	=	BURNING
..	=	TINGLING
OO	=	PAIN
XX	=	ACHE
SS	=	SORENESS



Additional comments:

Patient Signature: _____

Date: _____