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For the Treatment and Prevention of Pain

Things we need to know to help you get well:

Subjective: _____ Date: _____

Name: _____ Age: _____ Sex: _____

Home Telephone: _____ Work Telephone: _____

Employer: _____ Address: _____

Onset: (About your present problem)

Describe when and how you first developed the problem: _____

Describe past medical treatment: _____

X-rays taken? _____ Results: _____ Other tests: _____

Describe previous physical therapy: _____

Has the problem changed since its onset? (intensity, location, frequency)? _____

Occupation: _____ Job Description: _____

Tasks Required of Job: Lifting _____ Pushing _____ Pulling _____

Carrying _____ Sitting _____ Bending _____ Squatting _____

Standing _____ Walking _____ Max Wt. Lift _____ Squat _____

Avg. Wt. Lift _____

Regular Exercise _____ yes _____ no

Marital Status _____ Children and Respective Ages _____

Hobbies _____

Sleeping Pattern:

How long does it take you to get to sleep? _____ How many hours do you sleep without interruption? _____ What causes you to awaken? _____

Daily Routine:

Describe your activities during a typical day: _____

Nutrition:

Describe your eating habits: _____

Do you eat nutritiously? _____ yes _____ no

Smoking

Do you smoke? _____ yes _____ no Packs/day _____

How long have you smoked? _____

Medications:

Please list all medicines you are presently taking: _____

Are you allergic to any medications? _____ yes _____ no

If so, please list: _____

Sexual Function:

Do you have any discomfort during or after relations? _____ yes _____ no

Have you altered your normal position? _____ yes _____ no

Pain: Please draw on chart provided

Describe quality of pain: _____

Level (0 = no pain; 10 = worst pain) Rate at present: _____

Does it vary in intensity? Yes _____ No _____ How much? _____ to _____

Activities that Increase Pain:

Sitting _____

Standing _____

Walking _____

Bending _____

Lifting _____

Lying _____

Driving _____

Others: _____

Activities that Decrease Pain:

Walking _____

Sitting _____

Lying _____

Medications _____