

MADDEN PHYSICAL THERAPY

MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Medical History: Are you currently experiencing or have you had any of the following:

High Blood Pressure	YN	Heart Disease	YN	Numbness	YN
Bowel/Bladder Problems	YN	Pacemaker	YN	Cancer	YN
Shortness of Breath	YN	Weakness	YN	Pregnant	YN
Female Problems	YN	Diabetes	YN	Dizziness	YN
Night Pain	YN	Fatigue	YN	Osteoporosis	YN
Irregular Heart Rate	YN	Headaches	YN	Stroke	YN

Surgeries? Y N (List) _____

How would you rate your general health? (circle one) Poor Fair Good Excellent

In the past 3 months, have you experienced any significant changes in health (physical or mental) such as unexplained weight loss, depression, nausea, etc? (List) _____

List other medical problems: _____

Currently:

What is your current complaint? _____ When did it start? _____

Due to an injury? Y N (Explain) _____ Illness? _____

Did the symptoms begin: Suddenly or Gradually Previous problems in this area? Y N

Previous therapy for this condition? Y N What effect? _____

Have you had chiropractic or any other treatment for condition? Y N

Are you getting: Better Same Worse Are you better with rest? Y N

Does activity make you worse? Y N Which activities? _____

Are you worse in the: Morning Afternoon Evening Is your pain: Continuous Occasional

Does your pain radiate? Y N Where? _____

What reduces your pain? _____

What can't you do because of your symptoms? _____

Recent tests: X-ray CT MRI EMG Myelogram Other _____

Results: _____

What did the Doctor tell you is your diagnosis? _____

Did the physician put you on any restrictions? Y N List: _____

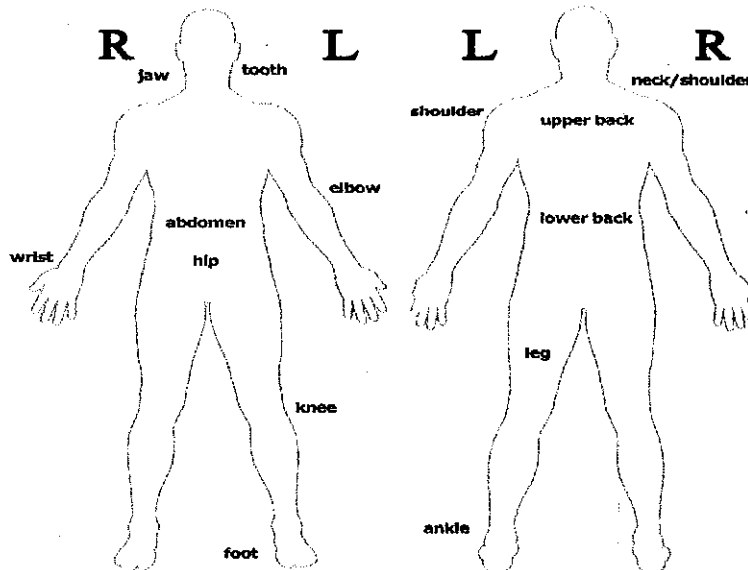
Are you currently employed? Y N What are your job tasks? _____

Based upon a 0 to 10 scale (0 is none and 10 is severe), what is your pain:

Right now: _____ Highest pain in past 24 hours: _____ Lowest pain in past 24 hours: _____

PLEASE COLOR YOUR AREA OF PAIN ON THE BODY DIAGRAM BELOW

FRONT



BACK

Madden Physical Therapy

LOW BACK PAIN QUESTIONNAIRE

1/11

Patient Name: _____ D.O.B. _____ Date: _____

CHOOSE ONLY ONE IN EACH CATEGORY THAT BEST DESCRIBES YOUR CONDITION

1. PAIN INTENSITY

- The pain comes and goes and is very mild.
- The pain is mild and does not vary much.
- The pain comes and goes and is moderate.
- The pain is moderate and does not vary much.
- The pain comes and goes and is very severe.
- The pain is severe and does not vary much.

2. PERSONAL CARE

- I would not have to change my way of washing or dressing in order to avoid pain.
- I do not normally change my way of washing or dressing even though it causes some pain.
- Washing and dressing increases the pain, but I manage not to change my way of doing it.
- Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- Because of the pain, I am unable to do some washing and dressing without help.
- Because of the pain, I am unable to do any washing and dressing without help.

3. LIFTING

- I can lift heavy weights without extra pain.
- I can lift heavy weights, but it causes extra pain.
- Pain prevents me from lifting heavy weights off the floor, but I manage if they are conveniently positioned.(e.g., on a table).
- Pain prevents me from lifting heavy weights off the floor.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can only lift very lightweights at the most.

4. WALKING

- I have no pain on walking.
- I have some pain on walking, but it does not increase with distance.
- I cannot walk more than one mile without increasing pain.
- I cannot walk more than ½ mile without increasing pain.
- I cannot walk more than ¼ mile without increasing pain.
- I cannot walk at all without increasing pain.

5. SITTING

- I can sit in any chair as long as I like.
- I can only sit in my favorite chair as long as I like.
- Pain prevents me from sitting more than one hour.
- Pain prevents me from sitting more than ½ hour.
- Pain prevents me from sitting more than 10 minutes.
- I avoid sitting because it increases pain right away.

6. STANDING

- I can stand as long as I want without pain.
- I have some pain on standing, but it does not increase with time.
- I cannot stand longer than one hour without increasing pain.
- I cannot stand for longer than ½ hour without increasing pain.
- I cannot stand longer than 10 minutes without increasing pain.
- I avoid standing because it increases the pain right away.

7. SLEEPING

- I get no pain in bed.
- I get pain in bed, but it does not prevent me from sleeping well.
- Because of pain, my normal night's sleep is reduced by less than ¼.
- Because of pain, my normal night's sleep is reduced by less than ½.
- Because of pain, my normal night's sleep is reduced by less than ¾.
- Pain prevents me from sleeping at all.

8. SOCIAL LIFE

- My social life is normal and gives me no pain.
- My social life is normal, but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- Pain has restricted my social life and I do not go out very often.
- Pain has restricted my social life to my home.
- I have hardly any social life because of the pain.

9. TRAVELLING

- I get no pain while traveling.
- I get some pain while traveling, but none of my usual forms of travel makes it any worse.
- I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
- I get extra pain while traveling, which compels me to seek alternative forms of travel.
- Pain restricts all forms of travel.
- Pain prevents all forms of travel except that done lying down.

10. CHANGING DEGREE OF PAIN

- My pain is rapidly getting better.
- My pain fluctuates, but is definitively getting better.
- My pain seems to be getting better, but improvement is slow at present.
- My pain is neither getting better nor worse.
- My pain is gradually worsening.
- My pain is rapidly worsening.