A BETTER LIFE d/b/a ABLE PHYSICAL THERAPY

35 JOURNAL SQUARE PLAZA, FIFTH FLOOR JERSEY CITY, NJ 07306
Tel: (866) 9NJ-ABLE/965-2253 Fax: (877) 9NJ-ABLE/965-2253

Communication between you and all health care practitioners involved in your care will ensure proper treatment. Please help us better understand your current medical condition in order to serve you better. Thanks!

Last Name: _____ First Name: _____

SS#: _____ DOB: _____

HISTORY OF PRESENT ILLNESS/INJURY QUESTIONNAIRE

1. What is the reason for your visit? Briefly describe how your symptoms began.
   _____
   _____
   _____
2. What was the date and location of onset, injury or accident?
   _____
3. Is this a recurring injury? Do you have any previous injury to this area?
   _____
4. Describe your symptoms (weakness, pain, numbness, tingling, sharp, dull, intermittent, constant, etc).
   _____
   _____
5. What makes your pain better (certain positions, activities, medications, heat, ice, etc)?
   _____
6. What makes your pain worse? _____
7. Please list any previous diagnostic tests (X-Rays, CT Scans, MRIs, EMGs, etc for this injury). Please give dates and results. It is also important to bring in any copies of relevant reports if available._____
   _____
   _____
8. Have you had any prior treatment for this condition?
   a. Medications:
      _____
      i. Any relief? _____
   b. Physical or Occupational Therapy? Where? _____
      i. Any improvement? _____
   c. Chiropractic care? Where? _____
      i. Any improvement? _____

   d. Procedures (injections, surgery, etc)? _____
      i. Any improvement? _____
   e. Equipment (cane, crutches, bracing, splinting)? _____
      i. Any improvement? _____
9. Functional Status (Circle One):
   a. Do you need help with basic activities of daily living (Feeding, dressing, grooming etc)? You are...
      <Independent /Need a Lot of Assistance / Need a Little Assistance / Dependent on Help>
   b. You walk on level surfaces and ascend/descend stairs…
      < Independently / With Help of Assistive Device / With Help of Someone >
   c. You get out of the bed or chair …
      < Independently / With Help of Assistive Device / With Help of Someone >
   d. How long can you sit for prior to onset of pain? _____ minutes
   e. How long can you stand prior to onset of pain? _____ minutes
   f. How long can you walk for prior to onset of pain? _____ minutes
   g. Do you have any medical equipment (cane, walker, tub bench, etc) ?
      _____
10. Who is your employer and how long have you been employed by them? _____
11. What is your occupation? _____
12. What are your job duties (lifting ____ lbs, prolonged standing, etc)?
    _____
13. Do your symptoms affect your work duties and how? _____
    _____
14. Are you currently working, out of work or working lite/modified duty? _____
15. How long have you been out of work? When is your anticipated date of return? Please list dates.
    _____
16. Did you voluntary take leave from work on your own? _____
17. Did your doctor take you out of work or modify your work duty? _____
18. Are you on temporary or permanent disability? If so, since when? If temporary, what is your anticipated date of returning to work? _____
19. Please provide name, telephone number and address of the doctor who put you on medical leave and other health providers involved in your care.
    _____
    _____
    _____

I attest that I have answered the above questions honestly and to the best of my ability.

Name: _____ Signature: _____ Date: _____

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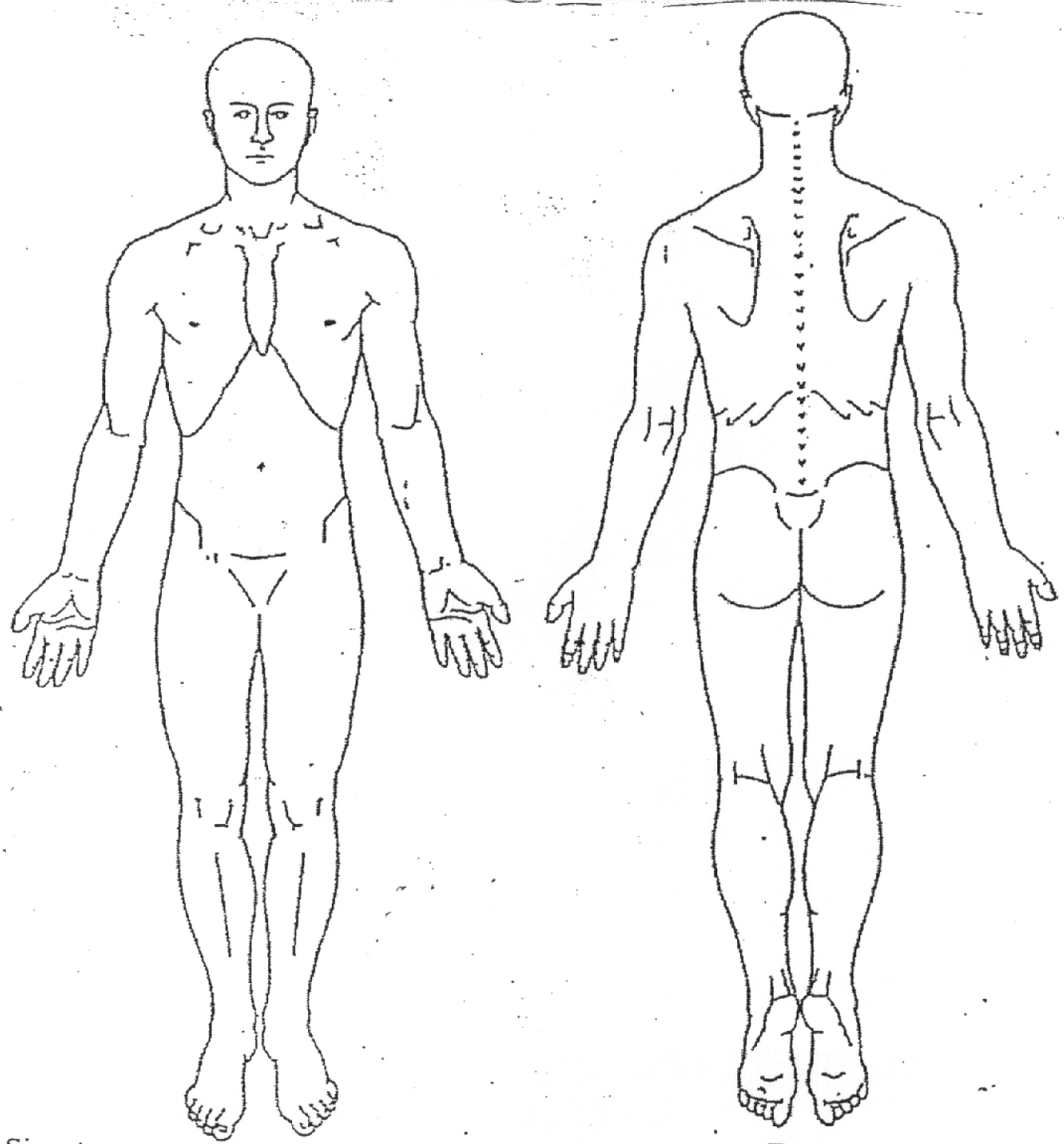
Name:	DOB:

Quantified Pain Drawing (Pre-Test)

After you review the key and body drawings below, please mark the corresponding pain symbol(s) on the body drawing. The drawings should only reflect the pain you feel at the present time. Only the pain type noted below should be marked on the body drawing. Do NOT indicate areas of pain that are not related to your present injury/condition.

KEY

/// Stabbing	XXX Burning	000 Pins and Needles	= = = Numbness



Signature:_____ Date:_____

Name:	DOB:

BORG 0-10+ RATING SCALE (PRE-TEST)

Please review the following scale and rate to your major area of pain from 0-10+. Pain ratings should be limited to the last 30 days and include 1) Pain Now 2) Pain o the Best Day 3) Pain on the Worst Day. Please use the descriptions to the right of thr numbers to assist in determining your pain ratings. For example, a pain rating of "1" is considered Very Weak Pain and a pain rating of "7" is considered Very Strong Pain.

10+ -- Maximal

10 -- Very, Very Strong

9 --

8 --

7 -- Very Strong

6 --

5 -- Strong

4 -- Somewhat Strong

3 -- Moderate

2 -- Weak

1 -- Very Weak

0.5-- Very, Very Weak

0 -- Nothing at All

Your Pain Ratings:

Pain Now: _____

Best Day: _____

Worst Day: _____

Signature: _____

Date:_____