Southeast HEALTH

PAIN ASSESSMENT

A. How would you describe your pain (circle all that apply)

____aching	____pins / needles	____numbness
____dull	____stabbing	____heaviness
____sharp	____burning	____other, explain_____

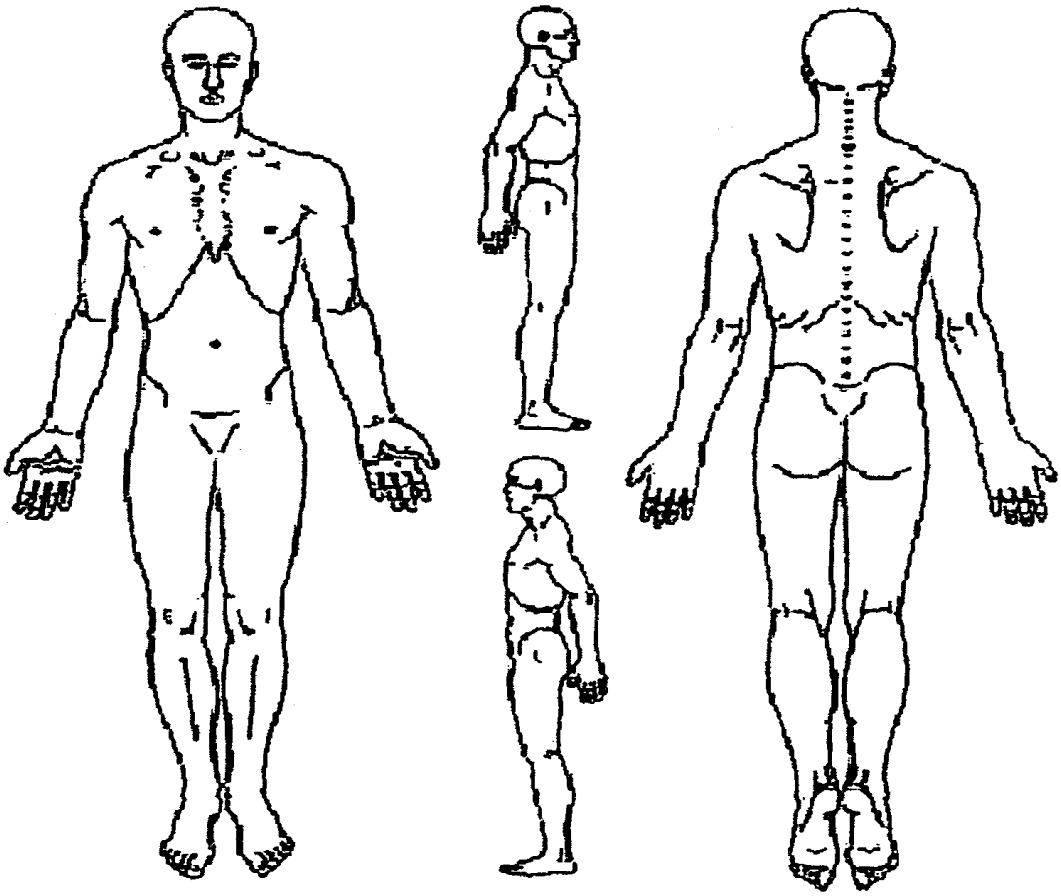
B. On a 0-10 scale, 0 is no pain and 10 is pain so bad you go to the emergency room for help, how would you rate your pain between 0 and 10?

At its best	____ (0-10)
At its worst	____ (0-10)
At rest	____ (0-10)
With activity	____ (0-10)

C. What makes your pain better?_____

D. What makes your pain worse?_____

E. Mark your pain on drawing



Patient Signature _____

Therapist/Physician _____

Southeast HEALTH

PARENT QUESTIONNAIRE/MEDICAL HISTORY

To help the therapist(s) better evaluate your child, please fill out this questionnaire and bring it with you to your child's initial evaluation.

PERINATAL AND PREGNANCY HISTORY

Please check if you or your child experienced any of the following during pregnancy or delivery.

- ❑ gestational diabetes
- ❑ high blood pressure
- ❑ preterm labor
- ❑ toxemia
- ❑ injury_____
- ❑ delivery at full term
- ❑ preterm delivery at_____ weeks
- ❑ vaginal delivery
- ❑ cesarean section
- ❑ other difficulties _____

Any medication taken during pregnancy

- ❑ prenatal vitamins
- ❑ other_____

Please list any other perinatal or pregnancy complications here: _____

CHILD'S MEDICAL HISTORY

- ❑ birth weight _____
- ❑ APGAR scores _____
- ❑ hospitalized _____ (days/weeks/months)
- ❑ required oxygen/ventilator
- ❑ seasonal allergies
- ❑ frequent ear infections
- ❑ surgeries and age of surgery_____
- ❑ any equipment or adaptive devices _____
- ❑ are immunizations current _____
- ❑ any previous PT/OT/ST _____
- ❑ illnesses or injuries _____

❑ please list any specialist(s) your child has or will be seeing

❑ please list any medications your child is taking and the reason why your child is taking that medicine _____

❑ does your child have any know drug or food allergies, if so please list_____

❑ please list any other information you believe is important for us to know regarding your child's medical history_____

Southeast HEALTH

PARENT QUESTIONNAIRE/MEDICAL HISTORY

Are you feeling sad, hopeless, or depressed today?_____ If yes, Are you having thoughts of self harm?_____

DEVELOPMENTAL HISTORY

Please specify the ages, as close to possible, at which your child performed each of the following activities:

Rolled over both ways_____
While on stomach, held head up_____
Crept on hands and knees_____
Stood alone_____
Spoke first word _____
Fed and drank independently_____
Able to dress self_____
Able to bathe self_____

Sat alone_____
Belly crawled _____
Pulled to stand _____
Walked independently_____
First sentence _____
Toilet trained _____
Undress self _____

Briefly describe your child's behavior on a typical day: _____
_____
_____
_____

CAREGIVER GOALS AND CONCERNS

- ❑ increase strength
- ❑ improve mobility
- ❑ achieve age appropriate development
- ❑ improve ability to follow directions
- ❑ improve handwriting skills
- ❑ improve behavior
- ❑ improve speech/language
- ❑ improve swallowing
- ❑ improve dressing/bathing/grooming skills
- ❑ decrease drooling
- ❑ improve feeding/eating
- ❑ improve visual skills
- ❑ other _____

_____
_____

Parent/Caregiver signature:_____ Date: _____

Therapist signature: _____ Date: _____

Southeast HEALTH

HEALTHPOINT REHAB
PATIENT SUMMARY INFORMATION

MEDICAL HISTORY

___ DIABETES
___ POOR CIRCULATION
where_____
___ SWELLING
where_____
___ RHEUMATIC FEVER
___ HEART MURMUR
___ IRREGULAR HEARTBEAT
___ HIGH BLOOD PRESSURE
___ LOW BLOOD PRESSURE
___ RHEUMATOID ARTHRITIS
___ THYROID PROBLEMS
___ VARICOSE VEINS
___ LUNG DISEASE
___ KIDNEY DISEASE
___ LIVER DISEASE
___ CANCER
when _____
where_____
___ DEPRESSION
___ OSTEOPOROSIS
___ STROKE
___ METAL IMPLANTS
where_____
___ MIGRAINE HEADACHES
___ STOMACH PROBLEMS
___ INCONTINENCE
bowel / bladder
___ ASTHMA
___ EPILEPSY / SEIZURES
___ HEARING PROBLEMS
___ VISION PROBLEMS
___ MULTIPLE SCLEROSIS
___ OSTEAOARTHRITIS
where _____
___ FIBROMYALGIA

Any other problems not listed above _____
Do you have a pacemaker?_____
Do you have any skin allergies?_____
Do you have any drug allergies?_____
Are you pregnant?_____ If so, when are you due? _____
Please list your current medications _____
_____
Please list any surgeries or hospitalizations, reasons and dates _____
_____

LIFESTYLE QUESTIONS

1. Do you engage in regular exercise?_____ If so, what type and how often _____
2. Do you smoke?____ Cigarettes Cigar Pipe Snuff/Chew How much? _____
3. Do you drink alcohol?_____ If so, how much?_____
4. What is your occupation?_____
   a. What are the physical demands of your job?
      Sedentary Light Medium Heavy Very Heavy
5. What is your education level? _____
6. Are you SINGLE MARRIED DIVORCED WIDOWED?
   a. If you have children, what are their ages?_____
7. Do you feel sad hopeless, or depressed today?_____
   a. If yes, Are you having thoughts of self harm?_____

THERAPY HISTORY AND GOALS:

1. Have you had therapy before: If so, please explain _____
2. Are you seeing any other medical professionals for the problem you are having now?
   _____
3. What are your goals for treatment here? (pain reduction, improve functional ability, return to work, sports, hobbies) _____

Patient Signature _____ Date/Time _____