Hopp Physical Therapy, Inc.
Specializing in Myofascial and Craniosacral Therapy
201 West Broadway • Council Bluffs, IA 51503 • (712) 329-9419 • FAX: (712) 329-0329

Name: _____

Date: _____

Gender: M F Age: _____

Height: _____ Weight: _____

Pain Assessment

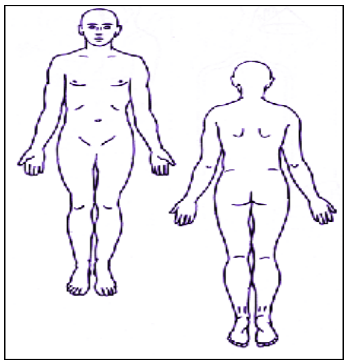
Area: please circle

Neck, Upper back, Lower back, Shoulder, Elbow, Wrist, Hand, Hip, Pelvis, Knee, Ankle, Foot - **Right, Left or Both**

When did your symptoms begin? _____

How did symptoms begin? _____

_____



Please rate your pain from 0 (no pain) to 10 (unbearable)

Worst	0	1	2	3	4	5	6	7	8	9	10
Current	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10

Describe your pain:

Sharp, Shooting, Ache, Burning, Numb, Tingling _____

What increases your pain? _____

Sitting, standing, walking, stairs, bending, lying down, other: _____

What decreases your pain? _____

Bending, sitting, standing, walking, lying down, rest, other: _____

Past medical history:

Do you have any of the following conditions? please circle

Alzheimer's, Cardiovascular Disease, CVA(stroke), Diabetes, Fibromyalgia, Fracture, High Blood Pressure, History of cancer, Obesity, Osteoarthritis, Parkinson's, Rheumatoid Arthritis, Traumatic Brain Injury, Unexplained weight loss, Pacemaker, Pregnant, Other: _____

Tests completed: X-Ray, CT scan, MRI, EMG, Ultrasound, Other:_____ Results: _____

Occupation: _____

Past Surgical History (List all and date):

_____

_____

_____

_____

_____

Current Medication List: Please list medications or provide list

_____

_____

_____

_____

_____

_____

Please answer the following questions by circling yes or no:

1. Are you basically satisfied with your life? **Y N***
2. Have you dropped many of your activities and interests? **Y* N**
3. Do you feel that your life is empty? **Y* N**
4. Do you often get bored? **Y* N**
5. Are you in good spirits most of the time? **Y N***
6. Are you afraid something bad is going to happen to you? **Y* N**
7. Do you feel happy most of the time? **Y N***
8. Do you often feel helpless? **Y* N**
9. Do you prefer to stay at home, rather than going out and doing new things? **Y* N**
10. Do you feel you have more problems with memory than most? **Y* N**
11. Do you think it is wonderful to be alive? **Y N***
12. Do you feel pretty worthless the way you are now? **Y* N**
13. Do you feel full of energy? **Y N***
14. Do you feel your situation is hopeless? **Y* N**
15. Do you think that most people are better off than you? **Y* N** Geriatric Depression Scale **(>5)**

If you are over 65 (or have Medicare for insurance), please answer the following questions yes or no:

Have you relied on people for any of the following: bathing, dressing, shopping, banking or meals? **Y N**

Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides, or medical care, or from being with people you wanted to be with? **Y N**

Have you been upset because someone talked to you in a way that made you feel shamed or threatened? **Y N**

Has anyone tried to force you to sign papers or to use your money against your will? **Y N**

Has anyone made you afraid, touched you in ways you did not want, or hurt you physically? **Y N**

Are you diabetic? If so, please indicate shoe size: _____

Are you a smoker? Yes or No (Please circle)

Do you use tobacco? Yes or No (Please circle)