CENTRAL OHIO PRIMARY CARE

Physical Therapy

Name:_____ **Date:**_____

Age:____ **Sex**: Male___ Female___ **Dominant Hand**: Right___ Left___

Diagnosis:_____

1. Pain is difficult to describe. Circle the words that best describe your symptoms:

Burning Throbbing Aching Stabbing Tingling Twisting Squeezing
Cramping Cutting Shooting Numbing Vague Stinging Indescribable
Pulling Smarting Pressure Coldness Dull Other: _____

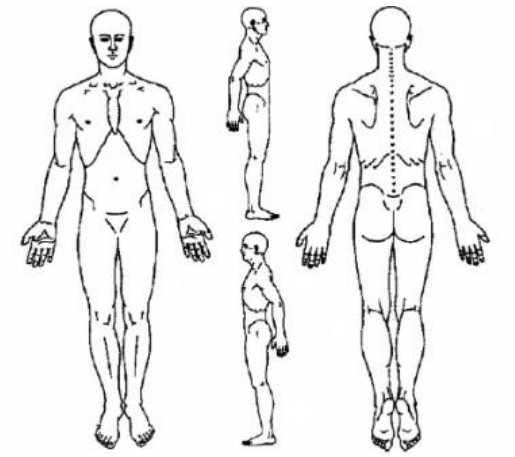
Level of symptoms: place a mark through the line to indicate the level of your pain, if zero is no pain and the end of the line is the most severe pain you can imagine having.

2. Mark your *average* level of pain *in the last month*
1_____5_____10
No Pain Most Severe Pain

3. Mark your *worst* level of pain *in the last week*
1_____5_____10

4. Mark on this scale how your pain has affected your quality of life:
1_____5_____10
Very Little A large amount

5. Where is your pain? (Draw on diagram)



Name _____

6. How did the pain that you are now experiencing occur?
Sudden onset Slow progressive onset "Flare up" of a prior injury

7. Does movement have any effect on your pain?
Makes it better Makes it worse No change

8. Does weather have any effect on your pain?
Makes it better Makes it worse No change

9. Do you have trouble with sleep because of your pain?
Trouble falling asleep awakened from sleep No trouble sleeping

10. Are you involved in any legal action regarding your physical complaint?
No Yes

11. Are you presently a victim of abuse?
No Yes No comment

12. Are you able to do your normal work and/or household chores?
Limited a lot Limited a little Not limited at all

13. How would you rate your overall health?
Excellent Good Fair Poor

Describe the problem for which you seek physical therapy _____
_____
_____

Describe how are you taking care of the problem now _____
_____

Describe what makes the problem better and what makes it worse _____
_____
_____
_____

Please list your goals for physical therapy. What would you like to be able to do when you are finished? Please be as specific as possible.

_____
_____
_____
_____
_____

If there is any medical or medication history that has changed since the last time you saw your doctor? _____
_____

CENTRAL OHIO℠
PRIMARY CARE
Physical Therapy

Oswestry Neck Pain Scale

Name: _____

Date: _____

Please rate the severity of your pain by circling a number :

No Pain ⟶ Unbearable pain									
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Section 1 – Pain Intensity

0 I have no pain at the moment.
1 The pain is mild at the moment.
2 The pain comes and goes and is moderate
3 The pain moderate and does not vary much.
4 The pain is severe, but comes and goes.
5 The pain is severe and does not vary much.

Section 2 – Personal Care

0 I can look after myself without causing extra pain.
1 I can look after myself normally, but it causes extra pain.
2 It is painful to look after myself and I am slow and careful.
3 I need some help, but manage most of my personal care.
4 I need help every day in most aspects of self-care.
5 I do not get undressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

0 I can lift heavy weights without extra pain.
1 I can lift heavy weights but it causes extra pain.
2 Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g on a table)
3 Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4 I can lift only very light weights.
5 I cannot lift or carry anything at all.

Section 4 – Reading

0 I can read as much as I want to with no pain in my neck.
1 I can read as much as I want to with slight pain in my neck.
2 I can read as much as I want to with moderate pain in my neck.
3 I cannot read as much as I want to because of moderate pain in my neck.
4 I cannot read as much as I want to because of severe pain in my neck
5 I cannot read at all.

Section 5 – Headache

0 I have no headaches at all.
1 I have slight headaches that come infrequently.
2 I have moderate headaches that come infrequently.
3 I have moderate headaches that come frequently.
4 I have severe headaches that come frequently.
5 I have headaches almost all the time.

Section 6 – Concentration

0 I can concentrate fully when I want to with no difficulty.
1 I can concentrate fully when I want to with slight difficulty.
2 I have a fair degree of difficulty in concentrating when I want to.
3 I have a lot of difficulty in concentrating when I want to.
4 I have a great deal of difficulty in concentrating when I want to.
5 I cannot concentrate at all.

Section 7 – Work

0 I can do as much work as I want to.
1 I can do my usual work but no more.
2 I can do most of my usual work, but no more.
3 I cannot do my usual work.
4 I can hardly do any work at all.
5 I cannot do any work at all.

Section 8 - Driving

0 I can drive my car without any neck pain.
1 I can drive my car as long as I want with slight pain in my neck.
2 I can drive my car as long as I want with moderate pain in my neck.
3 I cannot drive my car as long as I want because of moderate pain in my neck.
4 I can hardly drive at all because of severe pain in my neck.
5 I cannot drive my car at all.

Section 9 – Sleeping

0 I have no trouble sleeping.
1 My sleep is slightly disturbed (less than 1 hour sleepless).
2 My sleep is mildly disturbed (1-2 hours sleepless).
3 My sleep is moderately disturbed (2-3 hours sleepless).
4 My sleep is greatly disturbed (3-5 hours sleepless).
5 My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

0 I am able to engage in all my recreational activities, with no neck pain at all.
1 I am able to engage in all of my recreational activities, with some pain in my neck.
2 I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
3 I am able to engage in only a few of my usual recreational activities because of pain in my neck.
4 I can hardly do any recreational activities because of pain in my neck.
5 I cannot do any recreational activities at all.

Westerville Physical Therapy
Northwest Physical Therapy
Sports, Spine and Joint Physical Therapy

614-392-2812

CENTRAL OHIO℠
PRIMARY CARE

Eastside Physical Therapy
614-865-3142

Valued COPC Physical Therapy Patient:

At Central Ohio Primary Care, it is our goal to give you the best care possible. In order to best serve all of our patients, we request the following:

- If you cannot keep your scheduled appointment, please call us at the number above to cancel the appointment at least 24 hours prior to the visit.
- If you miss an appointment, and fail to call to re-schedule or cancel, you may be assessed a No Show/Late Cancelation fee of $50.00 for an initial evaluation or $25.00 for an established follow-up visit.
- If you have 3 cancellations within a consecutive 3 week period, the Physical Therapist will be notified and will determine if your therapy should resume, or be discontinued.
- If you will be more than 10 minutes late, we may ask you to re-schedule your appointment. This will assure that we are giving you the full time you deserve to address all of your needs during treatment.

Thank you for helping us to provide our patients with the most convenient scheduling possible!

I have read this physical therapy policy and agree to the above.

Today's Date: _____

Printed Name: _____

Signature: _____