

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

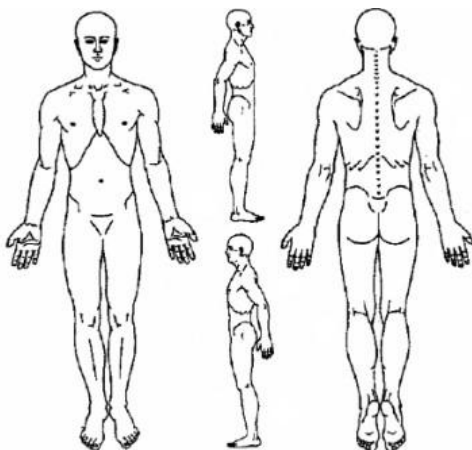
3. Mark your worst level of pain in the last week

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.

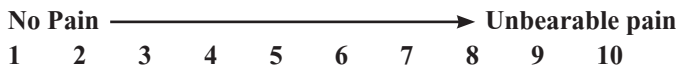
If there is any medical or medication history that has changed since the last time you saw your doctor? _____

Oswestry Low Back Pain Scale

Name: _____

Date: _____

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



Section 1 - Pain Intensity

- 0 The pain comes and goes and is very mild.
- 1 The pain is mild and does not vary much.
- 2 The pain comes and goes and is moderate.
- 3 The pain is moderate and does not vary much.
- 4 The pain comes and goes and is severe.
- 5 The pain is severe and does not vary much.

Section 2 - Personal Care (Washing, Dressing, etc.)

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

Section 3 - Lifting

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

Section 4 - Walking

- 0 I have no pain on walking.
- 1 I have some pain on walking but it does not increase with distance.
- 2 I cannot walk more than 1 mile without increasing pain.
- 3 I cannot walk more than 1/2 mile without increasing pain.
- 4 I cannot walk more than 1/4 mile without increasing pain.
- 5 I cannot walk at all without increasing pain.

Section 5 - Sitting

- 0 I can sit in any chair as long as I like.
- 1 I can sit only in my favorite chair as long as I like.
- 2 Pain prevents me from sitting more than 1 hour.
- 3 Pain prevents me from sitting more than 1/2 hour.
- 4 Pain prevents me from sitting more than 10 minutes.
- 5 I avoid sitting because it increases pain immediately.

Section 6 - Standing

- 0 I can stand as long as I want without pain.
- 1 I have some pain on standing but it doesn't increase with time.
- 2 I cannot stand for longer than 1 hour without increasing pain.
- 3 I cannot stand for longer than 1/2 hour without increasing pain.
- 4 I cannot stand for longer than 10 minutes without increasing pain.
- 5 I avoid standing because it increases the pain immediately.

Section 7 - Sleeping

- 0 I get no pain in bed.
- 1 I get pain in bed but it does not prevent me from sleeping well.
- 2 Because of pain my normal nights sleep is reduced by less than one-quarter.
- 3 Because of pain my normal nights sleep is reduced by less than one-half.
- 4 Because of pain my normal nights sleep is reduced by less than three-quarters.
- 5 Pain prevents me from sleeping at all.

Section 8 - Social Life

- 0 My social life is normal and gives me no pain.
- 1 My social life is normal but it increases the degree of pain.
- 2 Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
- 3 Pain has restricted my social life and I don't go out very often.
- 4 Pain has restricted my social life to my home.
- 5 I have hardly any social life because of the pain.

Section 9 - Traveling

- 0 I get no pain when traveling.
- 1 I get some pain when traveling but none of my usual forms of travel make it any worse.
- 2 I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- 3 I get extra pain while traveling which compels to seek alternative forms of travel.
- 4 Pain restricts me to short necessary journeys under 1/2 hour.
- 5 Pain restricts all forms of travel.

Section 10 - Changing Degree of Pain

- 0 My pain is rapidly getting better.
- 1 My pain fluctuates but is definitely getting better.
- 2 My pain seems to be getting better but improvement is slow.
- 3 My pain is neither getting better or worse.
- 4 My pain is gradually worsening.
- 5 My pain is rapidly worsening.



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 Cancellation 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: _____