PERFORMANCE REHAB
780 WEST LAUREL AVENUE • FOLEY, AL 36535
(251) 970-3839 (P) • (251) 970-3840 (F)
contact@performancerehabpt.com • www.PerformanceRehabPT.com

Personal Data Sheet

Today's Date: _____ Referring Doctor: _____

Date/Time of next doctor appointment: _____

Injury/Surgery date (If applicable): _____ Was this an accident? Y N

Please explain: _____

Have you had any previous therapy this year? If yes, when? _____

Have you had home health care recently? If yes, when? _____

PATIENT INFORMATION

Name: _____ DOB: _____

SSN: _____ Marital Status: M S D Sep W

Home phone: _____ Cell Phone: _____

Street Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

Email address: _____

Employer/Occupation: _____ Work Phone: _____

RESPONSIBLE PARTY (Leave blank if same as patient.)

Name: _____

DOB: _____ SSN: _____ Dr. Lic. #: _____

Home phone: _____ Cell Phone: _____

Street Address: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____

EMERGENCY CONTACT

Name: _____ Relation: _____

Home phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

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Medical History

Name: _____ Age: _____ Date: _____

Medical History: (Please complete the following regarding your current and past health.)

Have you had?	Yes	No	Comments	Have you had?	Yes	No	Comments
Heart Disease				Cancer			
Heart Attack				Fibromyalgia			
High Blood Pressure				Arthritis			
Pacemaker				Osteoporosis			
Stroke				Seizures			
Pneumonia				Headaches			
Emphysema/COPD				Thyroid Disease			
Asthma				Anemia			
Diabetes				Fractures			
Hepatitis				Kidney Problems			
Epilepsy				Depression			

List surgeries with dates

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

Current Medications (Prescription and over the counter)

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____

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Pain Form

Name: _____ Age: _____ Date: _____

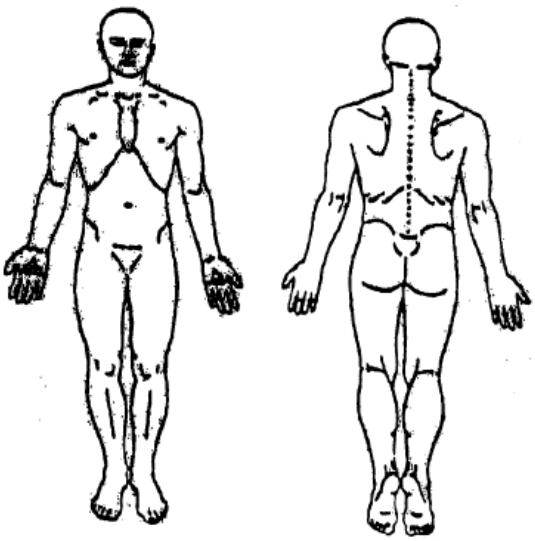
Please describe the nature of your pain

- ○ Sharp Pain
- ○ Dull Ache
- ○ Throbbing
- ○ Numbness
- ○ Shooting
- ○ Burning
- ○ Tingling

Please check one box:

- ○ Constant (76-100%)
- ○ Frequent (51-75%)
- ○ Occasional (26-50%)
- ○ Intermittent (24% or less)

Please mark on the picture the site of your pain/symptoms



Functional Pain Scale

0	No pain or discomfort
1-2	Non-disabling pain: Pain is present, but not yet at a level which limits you from performing the current activity
3	Functionally disabling pain: Pain that is starting to affect your ability to perform the current activity (i.e. decreased movement, decreased speed, and/or the need to briefly rest and/or stretch in order to continue completing the current activity
4	Pain that causes disability between levels 3 and 5
5	Very disabling pain: causes great difficulty moving or applying any strength through the painful area. You are unable to complete the current activity
6	Pain that causes disability between levels 5 and 7
7	Severely disabling pain: you cannot use or move the painful area. You have difficulty talking and concentration on anything but the pain. Needing to lie down and/or pain-related tearfulness are common at this level of pain.
8-9	Pain that causes disability between levels 7 and 10. You are nearing need for hospitalization.
10	Worst imaginable pain. It causes you to be completely incapacitated and barely able to talk. It requires immediate emergency hospitalization.

Use the above descriptions of pain to answer the following questions:

Intensity of your pain at **REST:** (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Intensity of your pain with **MOVEMENT:** (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Intensity of your pain at **WORST:** (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Since this condition began, your symptoms have: **DECREASED** **NOT CHANGED** **INCREASED**

Your symptoms are worse in the: **MORNING** **AFTERNOON** **NIGHT**

INCREASED DURING THE DAY **SAME ALL DAY**