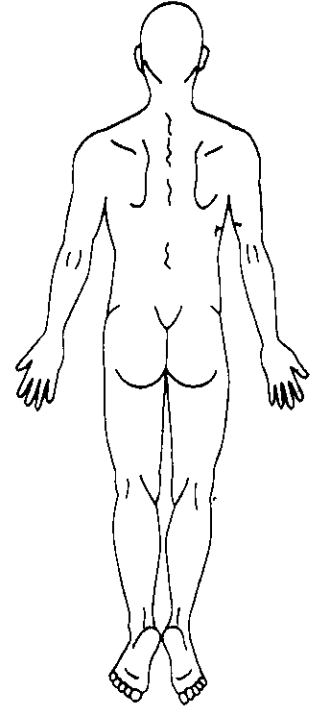
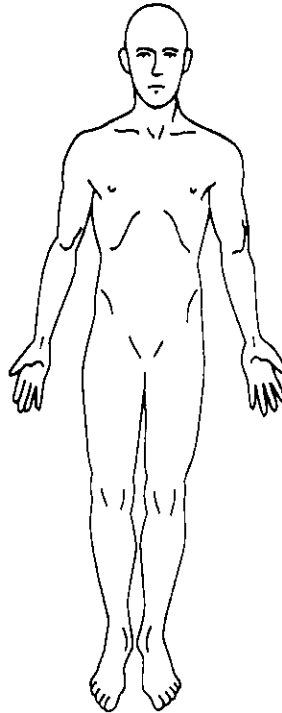




# Carolina Orthopedic Rehab



Please look at the body diagram and shade in the areas of pain using these symbols to show the type of pain.

- ~~~ Burning      /// Stabbing
- <<< Aching      o o o Numbness
- x x x Throbbing    | | | Shooting

Please look at the pain scale below and circle the number that best describes the severity of your pain. 0 means no pain, 5 would be moderate, and 10 would be unbearable pain.

### NECK & BACK PAIN

1 2 3 4 5 6 7 8 9 10

### ARM OR LEG PAIN

1 2 3 4 5 6 7 8 9 10

### OTHER AREAS OF PAIN

1 2 3 4 5 6 7 8 9 10

1. Give a brief history of your injury or onset of pain \_\_\_\_\_

\_\_\_\_\_

2. Have you had a previous history of similar problems?     Yes     NO

If you answered yes, what helped to relieve your pain? \_\_\_\_\_

\_\_\_\_\_

3. List ALL Medications and dosage: \_\_\_\_\_

\_\_\_\_\_

4. List any medical information we have not asked for that would be helpful. Example: heart condition, pacemaker, metal implants, skin conditions or allergies, etc. \_\_\_\_\_

\_\_\_\_\_

5. Please fill in the following:

- a) Marital Status \_\_\_\_\_
- b) Family at home \_\_\_\_\_
- c) # of Steps at home \_\_\_\_\_
- d) Employer \_\_\_\_\_
- e) Height \_\_\_\_\_
- f) Weight \_\_\_\_\_

6. How many falls have you had in past year \_\_\_\_\_

How many falls were you injured \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_