PLEASE COMPLETE THIS FORM AS ACCURATELY AS POSSIBLE. ALL INFORMATION PROVIDED WILL BE TREATED AS CONFIDENTIAL HEALTH INFORMATION.

Please mark all that apply:

- □ Cardiac (heart) disorder
- □ Chest pains
- □ Shortness of Breath
- □ Numbness or Tingling
  - □ Arms
  - □ Hands
  - □ Legs
  - □ Feet
- □ High Blood Pressure
- □ Pulmonary (lung) Disorder
- □ Emphysema
- □ Respiratory Infections
- □ Excessive Bleeding/Bruising
- □ Joint Problems
- □ Arthritis
- □ Bone Disorder
- □ Bone Fracture
- □ Osteoporosis
- □ Nerve Damage
- □ Dizziness
- □ Fainting
- □ Hearing Impairment
- □ Depressive Disorder
- □ Allergies
- □ Diabetes
- □ Hypoglycemia
- □ Asthma
- □ Blurred Vision
- □ Cancer
- □ MRSA
- □ Hepatitis
- □ Current Pregnancy
- □ Latex Allergy
- □ Other:

Please describe any of the items checked above:

_____
_____
_____

List any significant past medical history:

_____
_____
_____

Please list all medications currently taken:

_____
_____
_____

1. Do you currently smoke? □ YES □ NO
2. Have you ever thought about quitting? □ YES □ NO
3. If yes to #2, would you like information on smoking cessation programming? □ YES □ NO

Client Signature: _____ Date: _____

REHAB SERVICES HEALTH QUESTIONNAIRE

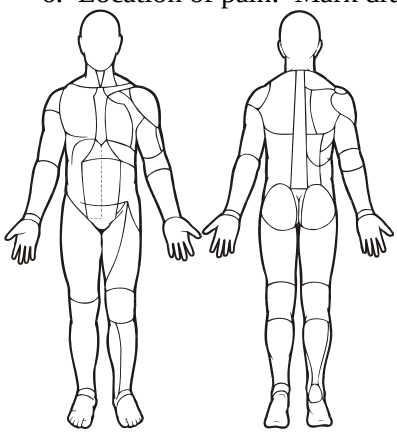
Pulaski Memorial Hospital
Winamac, IN 46996
(574) 946-2157
Form MM-258 Rev. 11/2009

1. Are you currently experiencing pain? ☐ Yes ☐ No
   Are you currently taking pain medications? ☐ Yes ☐ No

2. When did you start having problems? _____
3. Was an injury or unusual activity involved with the onset of you pain/problem? If so, what?
   _____
4. Where is your pain/problem located? _____
5. Circle the words that describe your pain.

Aching	Sharp	Penetrating
Throbbing	Tender	Nagging
Shooting	Burning	Numb
Stabbing	Exhausting	Miserable
Gnawing	Tiring	Unbearable

6. Location of pain: Mark drawing at pain location and use arrow to show direction of radiation.



0 1 2 3 4 5 6 7 8 9 10

no pain **worst possible pain**

7. Intensity/Severity: How bad is the pain?

At Present	0-10 scale	_____
At worst (last 24 hrs)	0-10 scale	_____
At Best pain gets	0-10 scale	_____
Acceptable level of pain	0-10 scale	_____

8. What relieves your pain? (Circle what applies)

   Heat, cold, activity, distraction, environmental control, exercises, massage, music,

   movement, medication, positioning, relaxation, other:

   _____

9. Pain Effects: Has pain resulted in changes in (circle any of the following that apply and elaborate if needed)?

   ADL function, activities, sleep, appetite, confusion, independence, quality of life, depression, mobility, continence, rehabilitation, restorative efforts, other: _____

10. What makes the pain worse? (Circle response, if known.)

    Activity, social interaction, position, movement, anxiety, depression, medication, worse at night,

11. Are you satisfied with current pain control? ☐ Yes ☐ No

Client Signature:_____ Date:_____

REHAB SERVICES PAIN ASSESSMENT

Pulaski Memorial Hospital
Winamac, IN 46996
(574) 946-2157
Form MM-257 Rev. 11/2009