Case Ref: ______ Date: ______

Patient Pre-Assessment Questionnaire

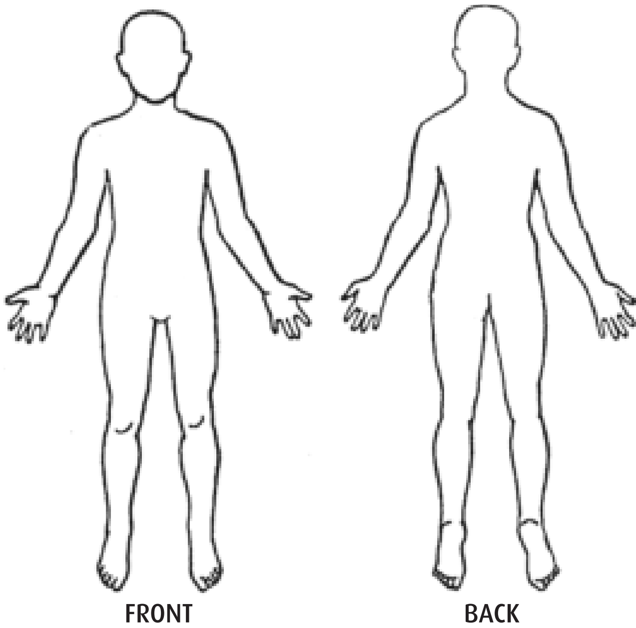
NAME: ______ **MALE** ☐ **FEMALE** ☐ **DATE OF BIRTH:** DD / MM / YYYY

PHONE: (Mobile) ______ **(Home)** ______

EMAIL: ______ **ADDRESS:** ______

______ **POSTCODE:** ______

SITE OF PAIN:
(please shade where applicable using crosshatch # to indicate main area of pain and single line // for less painfull areas)



TYPE OF PAIN: *(please tick all that apply)*

- ☐ SHARP
- ☐ PINS & NEEDLES
- ☐ SHOOTING PAIN
- ☐ STABBING PAIN
- ☐ ACHING
- ☐ DULL

HOW LONG HAVE YOU HAD THE PAIN?
(roughly when did it start)?

______

WHAT WERE YOU DOING WHEN THE PAIN STARTED? *(any accidents/falls/illnesses that could have triggered the pain symptoms)*

______

HOW OFTEN DO YOU SUFFER FROM THIS PAIN? CONTINUOUSLY ☐ DAILY ☐ WEEKLY ☐ INTERMITTENT ☐

ARE THERE ANY PARTICULAR MOVEMENTS/ ACTIVITIES THAT AGGRIVATE THE PAIN?
(please also refer to the pain review questionnaire for full details)

______

HAVE YOU HAD ANY PREVIOUS INVESTGATIONS? SCANS ☐ X-RAYS ☐ MRI ☐ BLOOD TESTS ☐

OTHER ______

ARE YOU CURRENTLY TAKING ANY MEDICATIONS FOR PAIN RELIEF? *(please specify)* ______

HOW EFFECTIVE DO YOU FEEL THESE ARE?
NO SIGIFICANT REDUCTION IN PAIN ☐ MODERATE RELIEF ALLOWING NORMAL DAILY ACTVITY ☐ VERY EFFECTIVE PAIN RELIEF ☐

DO YOU TAKE ANY OTHER MEDICATION? ______

ANY PREVIOUS INJURIES/TRAUMA/SURGERIES?

BACK ☐ NECK ☐ HEAD ☐ KNEE (R) ☐ (L) ☐ SHOULDER (R) ☐ (L) ☐ HIP (R) ☐ (L) ☐

OTHER ______

Your general health - *please tick if you have any of the following*

	Yes	No
ANY MAJOR ILLNESS/HEALTH PROBLEM	☐	☐
HISTORY OF CANCER	☐	☐
DIABETES	☐	☐
HEART PROBLEMS	☐	☐
BLOOD PRESSURE PROBLEMS	☐	☐
CHEST/BREATHING PROBLEMS	☐	☐
STEROIDS	☐	☐
ANTICOAGULANTS	☐	☐
ANY BLADDER/BOWEL SYMPTOMS	☐	☐
UNEXPLAINED WEIGHT LOSS	☐	☐
RHEUMATOID ARTHRITIS	☐	☐
EPILEPSY	☐	☐
PREGNANCY (CURRENT)	☐	☐
ANY SURGERY/OPERATIONS	☐	☐
PREVIOUS FRACTURES	☐	☐
OSTEOPOROSIS	☐	☐
ANY OTHER JOINT PROBLEMS	☐	☐

PLEASE GIVE DETAILS:

PLEASE LIST ANY MEDICATIONS THAT YOU ARE TAKING OR BRING A PRINT OUT OF YOUR CURRENT PRESCRIPTION:

WHAT IS YOUR OCCUPATION?

PLEASE GIVE DETAILS OF ANY HOBBIES

Contraindications Checklist

Absolute Contraindications

- ☐ Medical instability following an acute episode e.g. CVA, DVT, PE, Asthma
- ☐ Uncontrolled angina
- ☐ Shortness of breath at rest
- ☐ Uncontrolled cardiac failure/paroxysmal nocturnal dyspnoea
- ☐ Neutropaenia
- ☐ Diarrhoea/ vomiting within last 14 days
- ☐ Proven chlorine allergy
- ☐ Patients weight in excess of evacuation equipment (25 stone or 159kg)

Relative Contraindications

- ☐ Recent radiotherapy/chemotherapy – within last 6 weeks
- ☐ Acute systemic illness/fever/high temperature
- ☐ Infections (eg: wound)
- ☐ Unstable diabetes
- ☐ Poorly controlled epilepsy
- ☐ Known aneurysm

Precautions

- ☐ Fear of water
- ☐ Renal failure/kidney pathology
- ☐ Skin conditions/eczema/ Impaired sensation
- ☐ 1st trimester of pregnancy
- ☐ Poor skin integrity/open/surgical wounds
- ☐ Hypotension
- ☐ Reduced vital capacity

Patient Pre-Assessment Questionnaire