

Name: _____ Date: _____

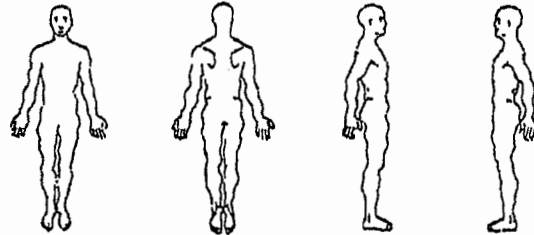
Please describe your current complaint or limitation: _____

What is your goal for therapy: _____

Please circle the best description that relates to the nature of your pain:

- Sharp pain
- Dull (pain) ache
- Throbbing
- Numbness
- Shooting
- Burning
- Tingling

- Constant (76-100%)
- Frequent (51-75%)
- Occasional (26-50%)
- Intermittent (25% or less)



(Mark on the where you have pain or other symptoms)

Indicate the intensity of your pain at rest: No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

Indicate the intensity of your pain with movement: No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable

What movement causes the pain to increase? _____

Since this condition began, your symptoms have: decreased not changed increased

Your symptoms are worse in: morning afternoon night increased during the day same all day

When did your problem begin: _____ days ago/months ago/years ago specific day ____/____/____

Describe how your problem began: _____

Did you have surgery? Yes No Date of surgery ____/____/____

Did you/are you receiving any type of home health care? _____

Have you had ANY prior physical therapy THIS year? _____

In the past, have you been treated for the same problem? Yes No

What makes your problem better? Nothing Lying down Standing Sitting Movement/Exercise Inactivity

What makes your problem worse? Nothing Lying down Standing Sitting Movement/Exercise Inactivity

Occupation: _____ F/T P/T

Has your work status changed because of this condition? Yes No

What is current work status? _____ Any restrictions/limitations at work? _____

Medications? If yes, please list: _____

Past or present medical history: _____