

Last Name _____ First Name _____ Date _____

1) In your own words, what has prompted you to seek physical therapy? _____

2) When was the date of onset for this issue? _____

3) How did this issue occur? _____

4) Are you experiencing pain? YES NO If yes, please rate your pain on the following scale:



0

1

2

3

4

5

6

7

8

9

10



No Pain/Symptoms

Moderate Pain/Symptoms

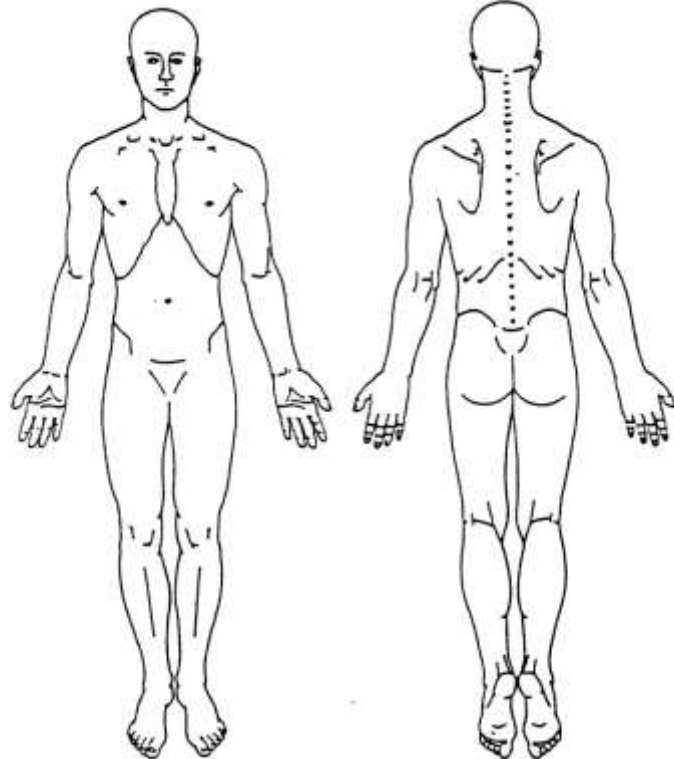
Severe Pain/Symptoms

On the Diagram below, please shade in the areas where you feel pain/symptoms. Put an X on the area that hurts the most.

FRONT **BACK**
RIGHT LEFT LEFT RIGHT

Please mark the symptoms you are experiencing:

- Sharp
- Crushing
- Shooting
- Numbness
- Dull
- Aching
- Intermittent
- Tingling
- Radiation
- Continuous
- Burning
- Tightness
- Throbbing
- OTHER: _____



What makes you feel better? _____

What makes you feel worse? _____

