Date _____ MR#_____

Please circle the number which best represents the severity of your pain.

At WORST the last 72 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

At BEST the last 72 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

AVERAGE over the last 72 hours:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Symptoms increase at night? ‰ Y ‰ N

Body Chart:
Please mark the areas where you feel pain on the chart to the right

What makes your symptoms worse?

What makes your symptoms better?

Have you received any treatment for this issue before? _____

Do you currently smoke? ‰ Y ‰ N If so how many times per day? _____

If you have quit smoking, how many years did you smoke for? _____

Do you consume alcohol? ‰ Y ‰ N If so how many times per day? _____

Do you use recreational drugs? ‰ Y ‰ N

Do you think you may be pregnant? ‰ Y ‰ N

Do you feel safe in your current living situation? ‰ Y ‰ N

Please list any functional activities you are currently having difficulty with or are unable to perform:

1. _____
2. _____
3. _____

What are your specific goals with physical therapy? _____

What methods of learning do you prefer? ‰ Written Information ‰ Verbal Instruction ‰ Demonstration

Patient Signature _____

Parent or Guardian: _____