Name ______________________________ Date __________

BONES/JOINTS & AREAS OF PAIN (CHECK ALL THAT APPLY)

- ☐ Lower Back
- ☐ Neck
- ☐ Abdomen
- ☐ Ribs
- ☐ Wrist/hands
- ☐ Feet
- ☐ Carpal tunnel
- ☐ Middle Back
- ☐ Head
- ☐ Tailbone
- ☐ Shoulders
- ☐ Hips
- ☐ Plantar fasciitis
- ☐ Upper Back
- ☐ Jaw
- ☐ Pelvic region
- ☐ Elbows
- ☐ Knees
- ☐ Sciatica

WHAT MAKES YOUR SYMPTOMS WORSE OR WHEN ARE THEY WORSE? (CHECK ALL THAT APPLY)

- ☐ Sitting
- ☐ Getting out of bed
- ☐ Work
- ☐ Household chores
- ☐ Menses
- ☐ Standing
- ☐ Getting up from sitting
- ☐ Morning
- ☐ Exercise or sports
- ☐ Other
- ☐ Walking
- ☐ Sleeping
- ☐ Evening
- ☐ Sexual intercourse

WHAT MAKES YOUR SYMPTOMS BETTER? (CHECK ALL THAT APPLY)

- ☐ Heating pad
- ☐ Resting in chair
- ☐ Stretching
- ☐ Ice pack
- ☐ Walking
- ☐ Medication
- ☐ Resting in bed
- ☐ Exercise
- ☐ Other

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM? (CHECK ALL THAT APPLY)

- ☐ Physical Therapy
- ☐ Massage
- ☐ None
- ☐ Acupuncture
- ☐ Medication
- ☐ Other
- ☐ Chiropractic
- ☐ Surgery

TYPES OF TREATMENTS THAT HELPED:

____

WHAT ARE YOUR GOALS OF PHYSICAL THERAPY?

____

PLEASE MARK AN "X" ON AREAS OF PAIN OR SYMPTOMS ON DIAGRAM

Please rate your symptoms on a scale of 1 to 10 (0=NO PAIN and 10=WORST PAIN IMAGINABLE, LIKE YOU NEED TO GO TO THE EMERGENCY ROOM)

CURRENT ________/10

BEST ________/10

WORST ________/10

CIRCLE YOUR CURRENT LEVEL OF FUNCTION FROM 1-10

(BARELY) **1 2 3 4 5 6 7 8 9 10** (FULL)