SYMPTOMS

Name: _____ Date: _____

What is your chief complaint? _____

Other concerns/complaints, if any: _____

What is your main goal with physical therapy (what do you want to do that you currently cannot do)?

_____

DESCRIPTION (please circle):

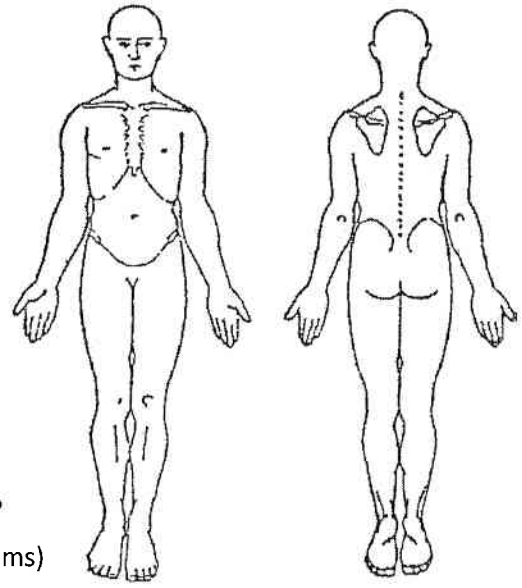
Numbness Tingling

Pain: Sharp Aching Burning Throbbing Shooting

Superficial Deep

Other: _____

LOCATION (mark on the figure):



INTENSITY (indicate on the line below how bad your symptoms are today):

(No symptoms) (Unbearable symptoms)

CHRONOLOGY / TIMING:

Tell when and how your symptoms started: _____

Are the symptoms _____ Better _____ Worse _____ Same ?

Symptoms worst in: _____ Morning _____ Midday _____ Evening _____ Night

Symptoms least in: _____ Morning _____ Midday _____ Evening _____ Night

Do symptoms keep you awake/awaken you? _____ Sleeping position (back, side, stomach): _____

FACTORS THAT INFLUENCE SYMPTOMS:

What increases your symptoms? _____

What decreases your symptoms? _____

What medication are you taking to relieve the symptoms? _____