Name: ____________________________

Reason for coming to physical therapy (chief complaint): _______________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

When did this current problem first start? __________________________________________________________

Have you previously experienced this problem? ____________ When? _________________________________

Have you missed work/school due to this condition? ____________ How much? ___________________________

My condition since onset is: (circle one) Better Worse Unchanged Fluctuating

My discomfort is: (circle one) Constant Intermittent

I feel **better** during: (circle one) Morning Midday Evening Night

I feel **worse** during: (circle one) Morning Midday Evening Night

Please rate your pain on a scale of 0-10: (0= no pain, 10= severe pain, intolerable)
Currently: _______ At best: _______ At Worst: _______

What activities/positions **increase or aggravate** the pain? (specific) _______________________________________

_______________________________________________________________________________________________

What activities/positions **decrease or relieve** the pain? (specific) _______________________________________

_______________________________________________________________________________________________

My typical activity level is: (place an x along the continuum):
Sedentary <_________________________________________________________________________________________ >Extremely Active

Goals you wish to achieve in physical therapy: _________________________________________________________

_______________________________________________________________________________________________