



Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1.	2.	3.
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What date (roughly) did your present symptoms start?

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

What do you think caused your symptoms? \_\_\_\_\_

My symptoms are currently: Getting better    Getting worse    Staying about the same

Treatment received for this problem (chiropractic, injections, etc): \_\_\_\_\_

Please list special tests performed for this problem (X-ray, MRI, labs): \_\_\_\_\_

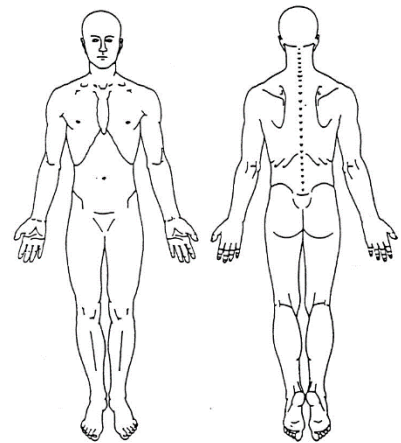
Have you ever had this problem before:    Yes    No    When: \_\_\_\_\_    Treatment rec'd: \_\_\_\_\_

How long did it take for you to feel better? \_\_\_\_\_

**Body Chart:**

Please mark the areas on the chart at right with the following symbols to describe and pinpoint where you feel symptoms.

- √ Shooting/sharp pain
- () Dull/aching pain
- ! Numbness
- = Tingling



My symptoms currently:     Come & go     Are constant     Are constant, but change with activity

**Aggravating Factors:** Identify three important positions or activities that make your symptoms worse:

**Easing Factors:** Identify three important positions or activities that make your symptoms better:

How are you currently able to sleep at night due to your symptoms?

- No problem sleeping     Difficulty falling asleep     Awakened by pain     Sleep only with medication

When are your symptoms worst?

- Morning     Afternoon     Evening     Night     After exercise

When are your symptoms the best?

- Morning     Afternoon     Evening     Night     After exercise

Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable", please describe:

Your current level of pain while completing this survey: \_\_\_\_\_

The best your pain has been during the past 24 hours: \_\_\_\_\_

The worst your pain has been during the past 24 hours: \_\_\_\_\_

What are your goals for physical therapy?