



Current Medical Condition

Patient Name: _____

Body part hurt/injured: _____

How were you injured? _____

Date of injury/onset (MM/DD/YY): _____ Date of surgery? (MM/DD/YY): _____

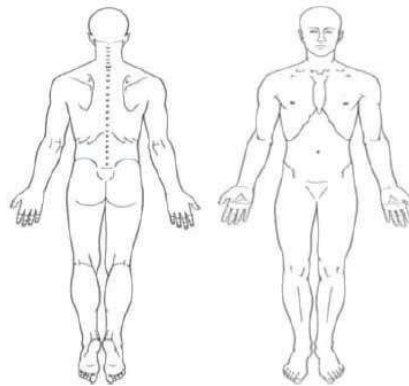
Students: What school do you attend? _____

Have you received physical therapy treatment this year? YES NO If yes, when? _____

Have you fallen in the last 12 months? YES NO If yes, when? _____

Patient Pain Assessment

Indicate where your pain is located using the pictures below



Chief Complaints / Problem List: _____

What makes your symptoms better? (Ex. Rest, medication) _____

What makes your symptoms worse? (Ex. Lifting, sitting, bending, stairs, squatting, kneeling) _____

Pain Scale

Please use the number scale to rate your pain level

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

CURRENT pain level _____ Pain at its **WORST** _____ Pain at its **BEST** _____

Patient/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____