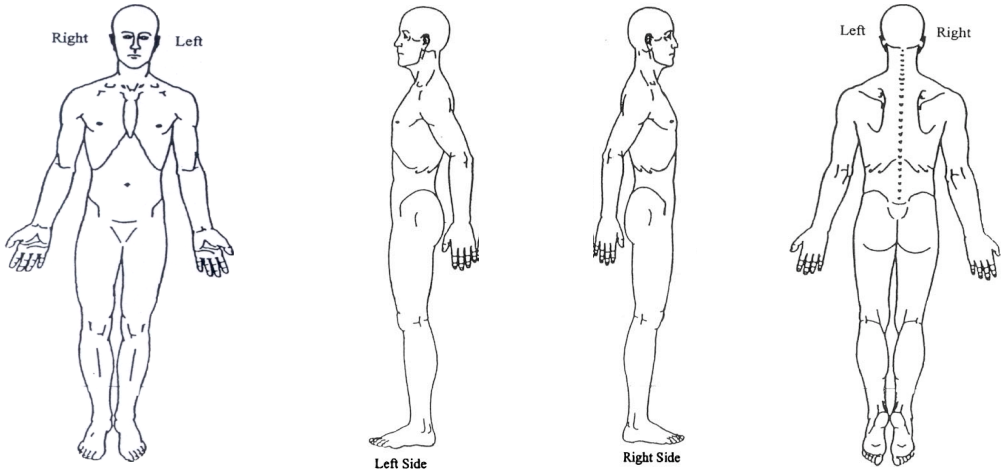
MODERN PHYSICAL THERAPY

Name: _____ Date: _____

Please fill in your area(s) of discomfort / symptoms. Do not use circles or X's. Instead, color in the areas(s) with a pen, as if you were drawing in a children's coloring book. Be as precise as you can about the exact area the symptoms occupy and what their boundaries are. Write in descriptive words where necessary (dull, sharp, better, worse, numbness, tingling, etc.). This form is a tool for you to communicate with us about progress and changes in your condition.



YOUR PAIN: (Please indicate your level of pain by circling a number from 0 to 10)

My current pain is No pain: 0 1 2 3 4 5 6 7 8 9 10 :Extreme pain

My best pain over last week No pain: 0 1 2 3 4 5 6 7 8 9 10 :Extreme pain

My worst pain over last week No pain: 0 1 2 3 4 5 6 7 8 9 10 :Extreme pain

My average pain over last week No pain: 0 1 2 3 4 5 6 7 8 9 10 :Extreme pain

Pain is: Not changing Getting better Getting worse

What activities increase symptom _____

_____

What activites are limited due to symptoms _____

_____