

SYMPTOMS AT START OF THERAPY PROGRAM:

Name: _____ Age: _____ Date ____/____/2009

1. My most bothersome neck / arm / hand &/or back / leg / foot symptoms & functional limitations now are _____

2. DIAGRAM YOUR PAIN & NUMBNESS SYMPTOMS-last 2 days into pictures below, follow directions beside:

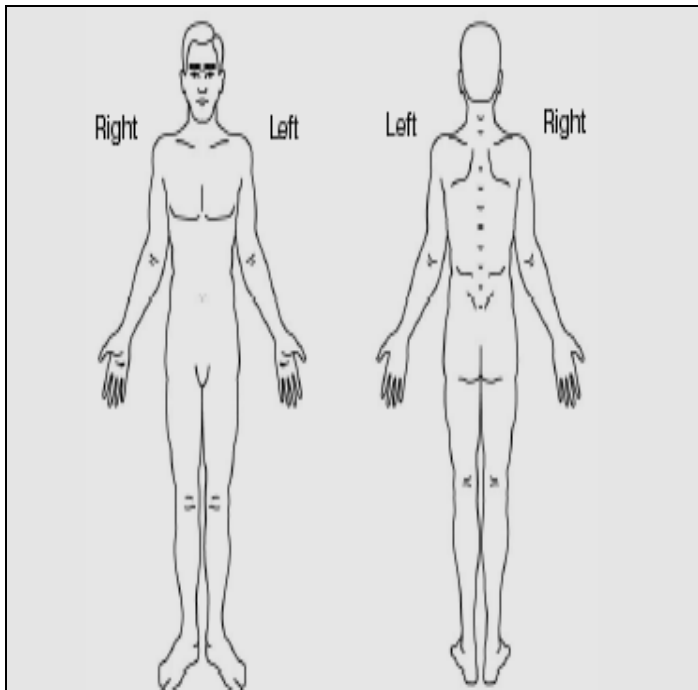


DIAGRAM in your PAIN - last 2 days

a. Shade in all areas of pain the last 2 days - front & back of body.

b. Indicate the approx. highest / lowest pain level for each major area of pain (last 2 days) using the pain scale of 0 to 10 as described below.

c. *No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Most severe pain possible
Pain Faces guide available in office to assist with pain levels

Write in an estimate of percentage, %, of the 24 hour day that the pain was present in each area of pain last 2 days. - Ex. If Present about 12 of 24 hr. day = 50%

DRAW IN AREAS OF NUMBNESS - last 2 days

a. Place the letter N(s) over the areas of numbness

b. Write in an estimate of percentage, %, of the 24 hour day that the numbness was present in each area last 2 days.

3. Describe any weakness &/or cramping in your arms &/or legs? _____

4. Describe any pain, stiffness &/or range of motion restrictions in your neck &/or low back _____

5. At this time, I can comfortably sit for _____ min., stand for _____ min., and walk for _____ min.

6. I am able to lift _____ lbs. frequently and _____ lbs. occasionally.

7. Activities that I am unable to perform the last couple months but would like to be able to after my therapy treatments are: _____

8. The types of medications that I am now taking for my neck, arm, hand &/or back, leg, foot symptoms are as below: None, muscle relaxants - as needed (p.r.n.) or _____ /day, anti-inflammatories- p.r.n. or _____ /day, pain medications- p.r.n. or _____ /day, narcotic pain medications - p.r.n. or _____ /day or other: _____

9. Past treatments for my back &/or neck pain included: (circle all that apply) Physical therapy _____ weeks, Aquatic therapy _____ weeks, Epidural injections _____ times, Acupuncture _____ Chiropractor _____ sessions, Surgery _____, other treatments _____

10. My exercise program at this time includes: _____

Patient Signature