

MY WEEKLY SYMPTOMS REPORT

Please complete this form so that we can accurately track your symptoms during your therapies.

Name: _____

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:

	<p>DIAGRAM in your PAIN - last 2 days</p> <p>a. Shade in all areas of pain the last 2 days - front & back of body.</p> <p>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.</p> <p>c. <i>*No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Most severe pain possible</i> <i><u>*Pain Faces" guide available in office to assist with pain levels</u></i></p> <p>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%</p> <p>DRAW IN AREAS OF NUMBNESS - last 2 days</p> <p>a. Place the letter N(s) over the areas of numbness</p> <p>b. Write in an estimate of percentage, %, of the 24 hour day that the numbness was present in each area last 2 days.</p>
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3. Describe any weakness &/or cramping in your arms &/or legs? _____

4. Describe any changes in pain, stiffness &/or range of motion restriction in your neck &/or low back since start of your physical therapy treatment in our office. _____

5. Last 2 days, 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. Some of the **activities** I am now able to do since I started my therapies include: _____

8. My **exercise program** at this time includes: _____

9. Any comments or questions? _____

Patient Signature