

MY SYMPTOMS AT COMPLETION THERAPY

CONGRATULATIONS ON COMPLETING THE PROGRAM!!

Name: _____ Age _____ Sex: Male/ Female 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:

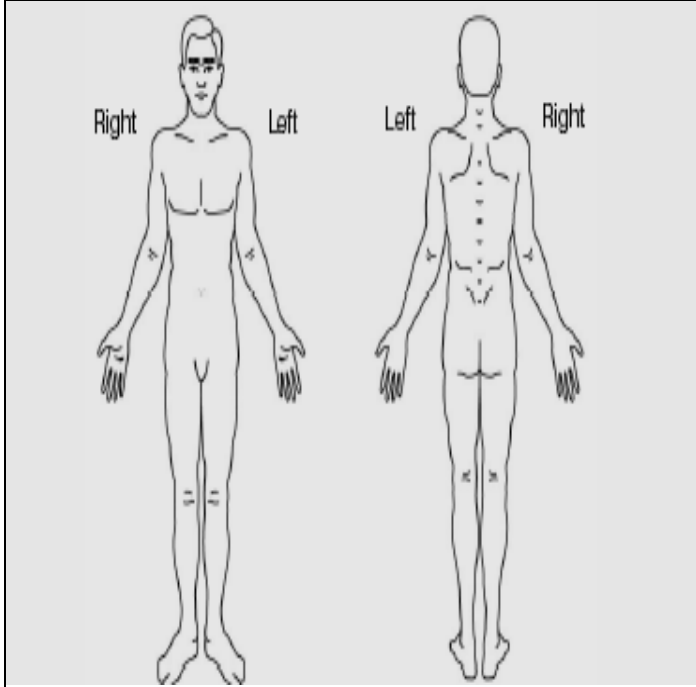


DIAGRAM in your PAIN - last 2 days

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.**

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

5. **I can now comfortably - sit** _____ mins., **stand** _____ mins., **walk** _____ mins, **Look up** _____ mins, **down** _____ mins, to the _____ right & _____ to the left. **I can now comfortably lift** _____ lbs. frequently & _____ lbs. occasionally.

6. Describe any changes in **medications** that you are taking in treatment of your back & neck pain/symptoms as you complete this treatment program (are you requiring less pain medications?) _____

7. **Activities** that I am now able to perform after this therapy treatment program but couldn't before treatments are: _____

My overall impressions of this Physical Therapy Treatment program are: _____

My recommendations to others considering this program are: _____

Other _____

I am willing to talk to patients who have questions about this treatment program – Yes / No. If yes, I can best be reached at _____ phone number.

Patient Signature