Physicians Group of Arizona

Physical Therapy

Name _____ Age_____ Date _____

Do you smoke:_____ If so, how many per day:_____

Describe your symptoms: _____

_____

When did your symptoms begin: _____

What makes the pain worse: _____

What makes the pain better: _____

Are you having numbness or tingling anywhere? _____

Indicate the intensity of your symptoms:

None Unbearable

1 2 3 4 5 6 7 8 9 10

Have you fallen within the past year:_____ If so, how many falls:_____

Hobbies/Leisure Activities:_____

What activities have you stopped since your injury:_____

_____

What do you do for work:_____

Describe your physical requirements for your job: _____

_____

Have you had physical therapy before? _____ Did it help? _____

Indicate where you have pain or symptoms: