

Patient Name: \_\_\_\_\_

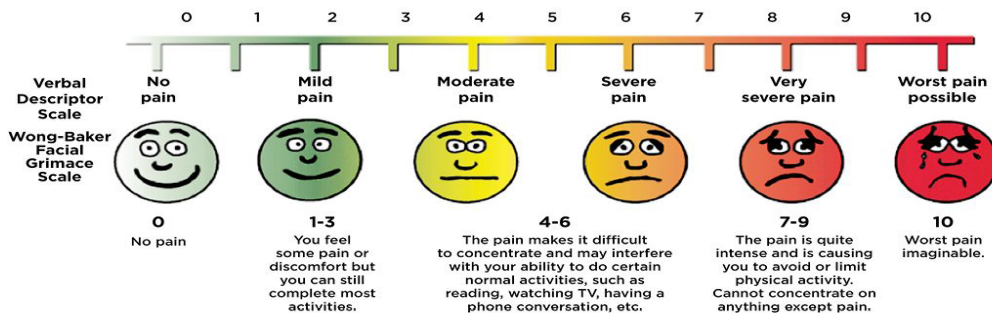
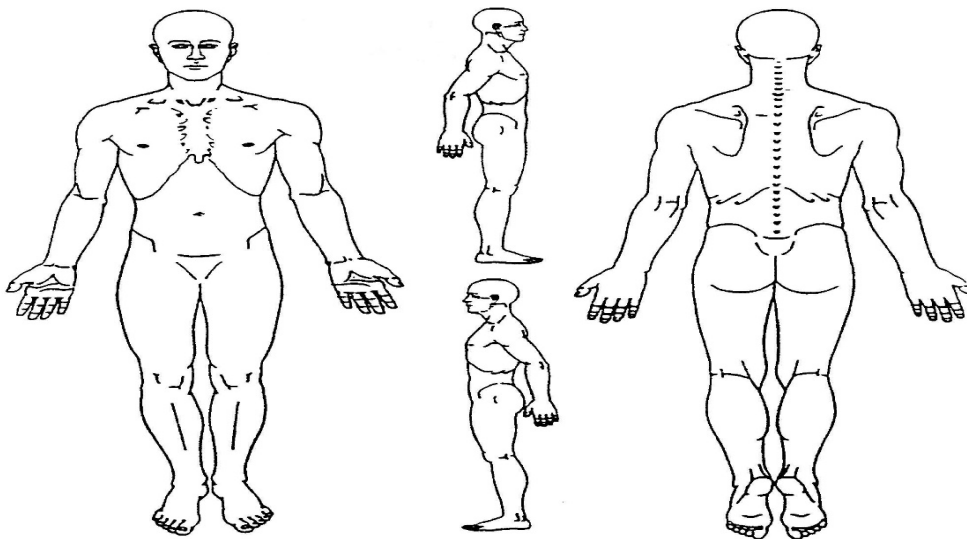
Reason for Therapy?

\_\_\_\_\_

What are your goals therapy for?

\_\_\_\_\_

Mark the areas of the body where you feel pain



Please choose a number from the pain scale above that best describes your pain

Right now, \_\_\_\_\_ Pain with activity \_\_\_\_\_ Pain at rest \_\_\_\_\_

Worst day in the past 30 days \_\_\_\_\_ Best day in the last 30 days \_\_\_\_\_