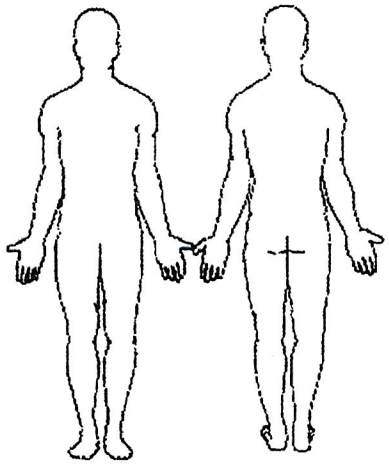
FYZICAL
Therapy & Balance Centers

Name: _____ Date: _____

Describe the location of your pain:



- ◻ Neck ◻ L ◻ R ◻ Both
- ◻ Back ◻ L ◻ R ◻ Both
- ◻ Shoulder ◻ L ◻ R ◻ Both
- ◻ Elbow ◻ L ◻ R ◻ Both
- ◻ Wrist ◻ L ◻ R ◻ Both
- ◻ Hip ◻ L ◻ R ◻ Both
- ◻ Knee ◻ L ◻ R ◻ Both
- ◻ Ankle ◻ L ◻ R ◻ Both
- ◻ Foot ◻ L ◻ R ◻ Both
- ◻ Other: Please mark on the picture

Describe the nature of your pain:

◻ Achy ◻ Burning ◻Dull ◻ Numbness ◻Sharp ◻Shooting ◻ Throbbing ◻Tingling

How long ago did your pain start? _____

Prior to the onset of your symptoms, how would you rate your level of function? (circle #)

Lowest 0 1 2 3 4 5 6 7 8 9 10 Highest

How often do you experience pain symptoms: ◻ Constantly ◻ Hourly ◻ Daily ◻ Other: _____

Rate your level of pain at its worst, at its best, and at its current level, where 0= no pain (circle #)

Worst	0	1	2	3	4	5	6	7	8	9	10
Best	0	1	2	3	4	5	6	7	8	9	10
Current	0	1	2	3	4	5	6	7	8	9	10

Have you had surgery? ◻ Yes, Date: _____ ◻ No