

[**www.dynamicsphysicaltherapy.com**](http://www.dynamicsphysicaltherapy.com)

**NAME** \_     \_ **AGE** \_     \_ **DATE** \_     \_

**BRIEF DESCRIPTION OF CURRENT PROBLEM**:

**HOW LONG HAVE YOU HAD PROBLEM**:       Days       Weeks       Months       Years

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**HAVE YOU HAD SURGERY?** Date

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**This next section will need to be completed by hand at the time of your visit:**

**1) Using the number rating system below, describe your:**

**Pain level *NOW*:**

Pain level at **BEST**:

Pain level at **WORST**:

(0-10)

(0-10)

(0-10)

 In the past ***30 days***:

 In the past ***30 days***:



 Pain Scale:

 0 1 2 3 4 5 6 7 8 9 10

 None Mild Moderate Severe

 **OOOO Pins and Needles**

 **XXXX Numbness**

 **////////// Pain**

 **= = = = Other**

Use the symbols listed above to describe the location and type of pain or unusual feelings you are having by drawing them on the pictures above

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**Use the symbols listed below to describe the location and type of pain or unusual feelings you are having by drawing them on the pictures.**

 **2)**