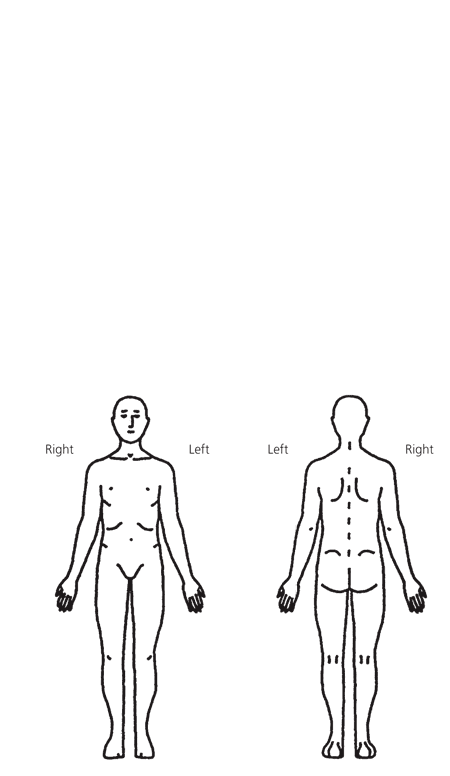


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**NAME** \_     \_ **AGE** \_     \_ **DATE** \_     \_

**BRIEF DESCRIPTION OF CURRENT PROBLEM**:

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

****

**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**:

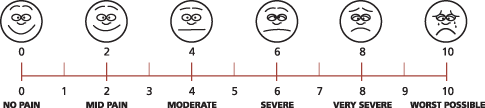
(0-10)

(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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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)**