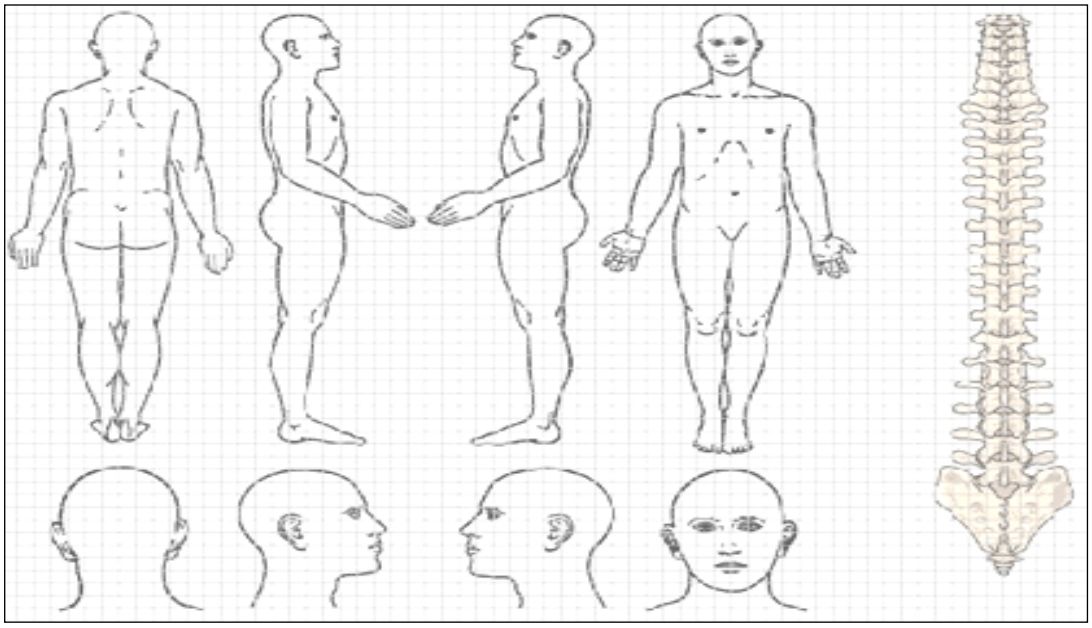
JOURNEY
PHYSICAL THERAPY

Patient Symptoms Report and Diagram

Name: _____ DOB: _____/_____/_____



Please circle the appropriate number below showing how bad your pain is now:

Now:	**No pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst possible pain**
At Worst:	**No pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst possible pain**
At Best:	**No pain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Worst possible pain**

1. **What is the purpose of Today's Evaluation?** _____
2. **Are you still working?** □ **Yes** □ **No** if not when was the last day on the Job**?** _____
3. **Occupation:**
4. **When (roughly what date) did your present pain start?**_____
   .
5. **How did symptoms start?** (Check appropriate box)

□ No apparent cause	□ Gradually	□ Twisting	□ Bending
□ Lifting	□ Fall	□ Pulling /Pushing	□ Suddenly

□ Injured during work Date:____/_____/_____	□ Injured in auto accident Date:____/_____/_____	□ Injured at sports Date:____/_____/_____

6. **Have you had similar pain?** □ Yes □ No □ Date ____/_____/_____
7. **Have you been hospitalized for your pain problem?** □ Yes □ No Date ____/_____/____
8. **How do you describe your pain?** □ Constant □ Intermittent
9. **What describes the nature of your symptoms?**

□ **Sharp**	□ **Shooting**	□ **Burning**
□ **Dull ache**	□ **Numb**	□ **Tingling**

10. What activities make the pain?

	Better	**Worse**	**No Difference**	**Comments**
□ **Exercise**				□ **During** □ **After**
□ **Lying down**				□ **supine** □ **right side** □ **left side**
□ **Sitting**				□ **How long**
□ **Standing**				□ **How long**
□ **Walking**				□ **Distance**
□ **Bending**				□ **forward / backward** □ **right side** □ **left side**
□ **Overhead activities**				
□ **Lifting / pushing / pulling**				
□ **Coughing / Sneezing**				
□ **Pain Medications**				
□ **Other**				

11. What medications are you currently taking? (If additional space is needed please use the back of this sheet) **12. Have you received any of the following tests?** **Date:**

□ **Diagnostic x-rays**	□**CT(computed tomography) scan**	□ **Electromyogram (EMG)**
□ **Discogram**	□ **MRI (magnetic resonance imaging)**	□ **Others _____**

13. In general would you say your overall health right now is…

□ **Excellent**	□ **Very good**	□ **Good**	□ **Fair**	□ **Poor**

14. Medical history (Circle Yes or No)

Allergies	**Y / N**	**Currently Pregnant**	**Y / N**	**Kidney Problems**	**Y / N**
Anemia	**Y / N**	**Depression**	**Y / N**	**Metal Implants**	**Y / N**
Anxiety	**Y / N**	**Diabetes**	**Y / N**	**Multiple Sclerosis**	**Y / N**
Arthritis	**Y / N**	**Dizzy Spells**	**Y / N**	**Osteoporosis**	**Y / N**
Asthma	**Y / N**	**Emphysema/Bronchitis**	**Y / N**	**Parkinsons**	**Y / N**
Cancer	**Y / N**	**Fractures**	**Y / N**	**Rheumatoid Arthritis**	**Y / N**
Cardiac Conditions	**Y / N**	**Gallbladder problems**	**Y / N**	**Seizures**	**Y / N**
Cardiac Pacemaker	**Y / N**	**Hepatitis**	**Y / N**	**Speech Problems**	**Y / N**
Chemical Dependency	**Y / N**	**High Blood Pressure**	**Y / N**	**Strokes**	**Y / N**
Circulation Problems	**Y / N**	**Incontinence**	**Y / N**	**Thyroid Disease**	**Y / N**
Tuberculosis	**Y / N**	**Vision Problems**	**Y / N**	**Other:**	

15. Fall History: □

Injury as a result of fall in the past year: Yes / No When: _____. □

Two or more falls in the past year: Yes / No When: _____. **16.**

Surgical History: (If additional space is needed please use the back of this sheet) □ Date:

/_____/_____ □ Body region: _____ □ Surgery type:

17. Do you have any additional information that would be helpful in understanding your problem?

Patient signature: _____Date: _____