TODD'S BODY SHOP
PHYSICAL THERAPY & REHAB

NAME: _____ TODAY'S DATE: _____

AGE: _____ WEIGHT: _____ HEIGHT: _____ OCCUPATION: _____

1. Describe the reason for your visit: _____

_____

2. Where is your pain? _____
3. When did it start? _____
4. Is your pain the result of an injury? If yes, describe briefly.

_____

5. Is your pain: constant or intermittent
6. Describe your pain: sharp dull achy deep burning throbbing

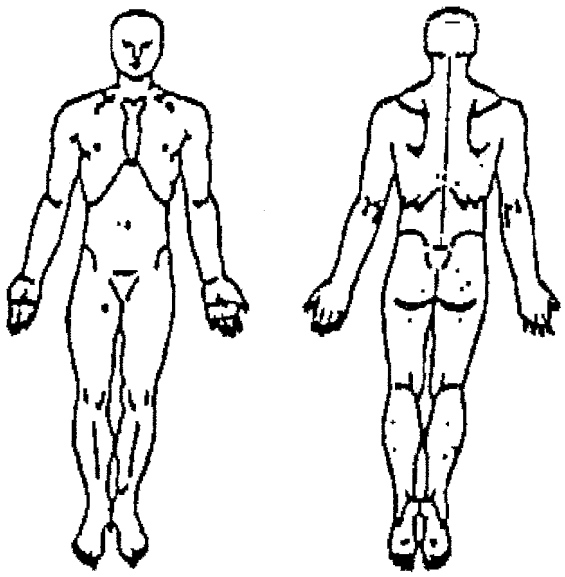
Rank your symptoms from 1-10. (1 being none, and 10 being unbearable)

At rest: _____ During activities: _____

7. What activities make your pain worse?

_____

Please draw pain pattern on body chart below:



8. What can you do to relieve your pain? _____
9. Does your condition affect your sleep? Yes or No. If yes, can you go back to sleep? _____
10. How do you feel in the morning? Stiff Sore Fine
11. Since this problem started what tests have been done? X-ray MRI CT Scan Lab work Other: _____

Dates/Results: _____

_____

12. Have you had anything similar to this condition (If so, please describe)? _____

_____

13. List all medications which you are taking: _____

_____

14. Do you exercise? If yes, please describe: _____
15. Is there anything else that you would like to add? _____