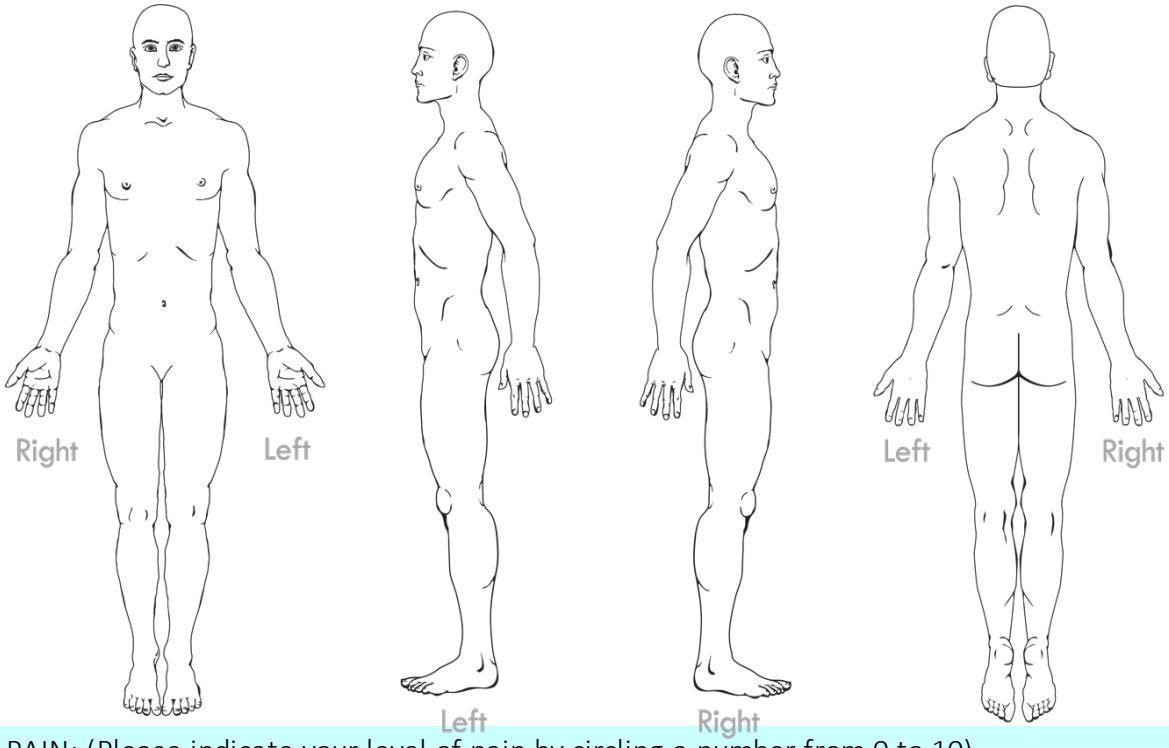
Name: _____ Date: _____

Please fill in your area(s) of discomfort / symptoms, drawing as specific as you can.



YOUR PAIN: (Please indicate your level of pain by circling a number from 0 to 10)

0/10: No Pain 1-3/10: Minimal Pain 4-6/10: Moderate Pain 7-9/10 Severe Pain 10/10: Need to go to the ER

My current pain is	0	1	2	3	4	5	6	7	8	9	10
My least amount of pain over last week	0	1	2	3	4	5	6	7	8	9	10
My worst amount of pain over last week	0	1	2	3	4	5	6	7	8	9	10
My average amount of pain over last week	0	1	2	3	4	5	6	7	8	9	10

Do you have times where you are pain free? Yes No

What percent of the time are you pain free? _____%

Pain is: Not changing Getting better Getting worse

Since your initial evaluation in PT, how much improvement have you noticed
if 0% is no improvement and 100% is completely better?

What have you noticed that you are able to do now, that you were not able to do at your initial visit

What have you *not* been able to do that you will really enjoy doing when this problem is solved?

What are your remaining goals in physical therapy?