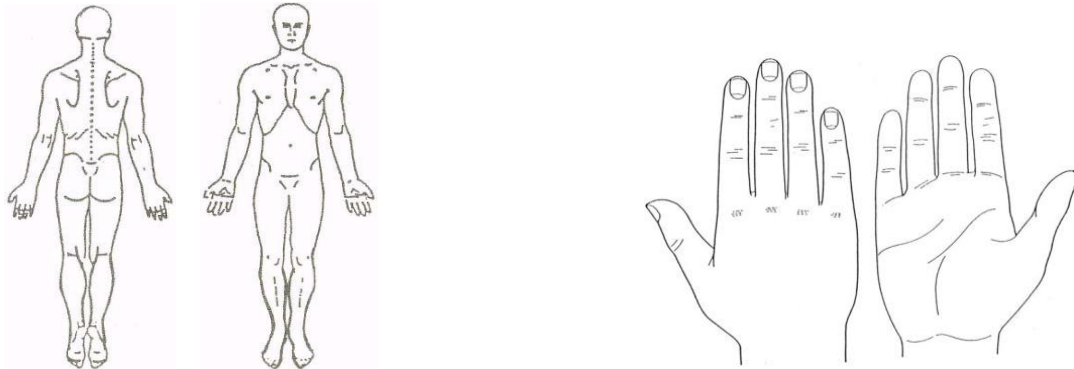




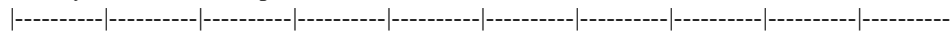
The Hand & Physical Therapy Center Of Marin
A Physical Therapy Professional Corporation

Patient Name: _____

1. Describe the nature of your problem and indicate on diagram where: _____



Please indicate your CURRENT pain level on the chart below:



0 1 2 3 4 5 6 7 8 9 10 No Pain Moderate Pain Worst Pain

2. What if any treatments have you had for this current problem?

Did they help? Yes ___ No ___

3. What in particular makes your pain worse?

4. What, if anything, eases the pain?

5. Can you get comfortable at night? Yes ___ No ___

6. How do you feel upon rising? Stiff ___ Sore ___ Fine ___

7. Once you start moving about, does it worsen ___ or ease ___?

8. What is it like at the end of the day? Worse ___ Easier ___

9. Do you have any pins and needles, etc? Yes ___ No ___ (if yes, please indicate location on diagram above)

10. At this time, do you consider you are getting better ___, worse ___ or stable ___?

Please rate your ability to perform the following activities:

1-Not Limited 2-Can do with some difficulty 3-Can do with significant difficulty 4-Can't do at all

Sleeping ___ Dressing ___ Sitting ___ Standing ___ Walking ___ Housework ___

Driving ___ Stairs ___ Sporting Activities ___ Sexual Activity ___ Yardwork ___

WHAT GOALS DO YOU WANT TO ACHIEVE WITH THERAPY? _____

Patient Signature: _____ Date: _____