Columbia University
Medical Center

Physical Therapy

Patient Name _____ MRN # _____

When did your symptoms start? _____

Briefly describe your symptoms _____

How did your symptoms start? _____

Average pain intensity last 24 hours: 0 1 2 3 4 5 6 7 8 9 10
Average pain intensity past week: 0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms? (***please circle one***)

1 – Constantly (76% - 100% of the time)
2 – Frequently (51% - 75% of the time)
3 – Occasionally (26% - 50% of the time)
4 – Intermittently (0% - 25% of the time)

How much have your symptoms interfered with your daily activities? (***please circle one***)

1 – Not at all 2 – A little bit 3 – Moderately 4 – Quite a bit 5 – Extremely

How is your condition changing, since care at *this* facility? (***please circle one***)

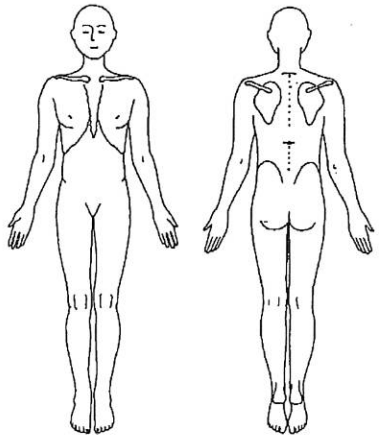
N/A – This is the initial visit 1 – Much worse 2 – Worse 3 – A little worse
4 – No change 5 – A little better 6 – Better 7 – Much better

In general, would you say that your overall health right now is…(***please circle one***)

1 – Excellent 2 – Very good 3 – Good 4 – Fair 5 – Poor

What makes it feel better? _____ What makes it feel worse? _____

Have you had any treatment for this problem? (***describe***): _____



Please draw your symptoms on the chart.
Key:
Pain: (XXXX) Numbness/tingling: (/////////)
Muscle Spasm: (ZZZZ) Radiating symptoms: (→→→)

Please rate your pain on a scale of 0-10.
(0=no pain, 10=requires Emergency Room visit):

Currently _____

At best, in the last 72 hours _____
At worst, in the last 72 hours _____

Are you allergic to latex? _____YES _____NO

Do you have any special equipment? (**canes, crutches, walker, exercise equipment**) _____

Do you do any regular exercise? If so, describe: _____