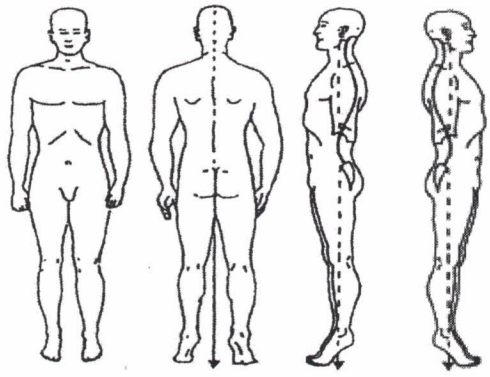
YOUR HEALTH PROFILE – TO BE COMPLETED WITH THE THERAPIST

Please briefly describe the chief area of complaint, including the affect it has had on your life, when you first noticed it, and how it originally occurred.

_____

_____

Indicate where you feel your symptoms on the diagram below:



Check the boxes that describe what you are feeling:

☐ Dull ☐ Sharp ☐Numbing ☐ Throbbing ☐Tingling ☐Aching ☐Burning ☐Stabbing ☐Cramping ☐Cutting
☐Stiff ☐Spasms ☐Stinging ☐Shooting ☐Pounding ☐Constricting ☐ Other:_____

When did it start? _____ It is: ☐About the Same ☐Getting Better ☐Getting Worse

What makes it worse?_____

How frequent is the complaint? ☐Constant ☐Daily ☐Intermittent ☐Night Only ☐ Other:_____

How long does it last? ☐ All day ☐A Few Hours ☐ Minutes ☐ Seconds

Is there anything you can do to relieve the problem? ☐Yes ☐No If yes describe: _____

It Interferes with: ☐Work ☐Sleep ☐Walking ☐Sitting ☐Hobbies ☐Leisure

Please indicate your level of pain/discomfort below by checking a number/circling a word:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
Normal *Mild* *Moderate* *Severe* *Excruciating*

*If your pain varies or you have multiple areas of pain at different levels, inform the therapist.

For Office Use Only.

Follow up Date_____
Comments_____
Referral call Date_____
$10_____