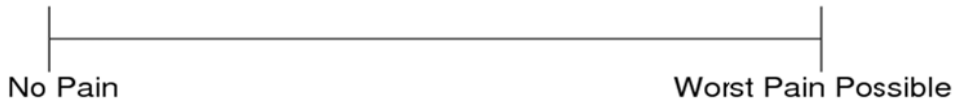
Date:_____Name_____Occupation:_____

Hobbies/Sports_____Medications:_____

Past Medical History/Surgeries_____



Please write down and score (from 0-10) **3 Functional Activities** in your life you are unable to perform or are having difficulty performing as a result of your chief problem.

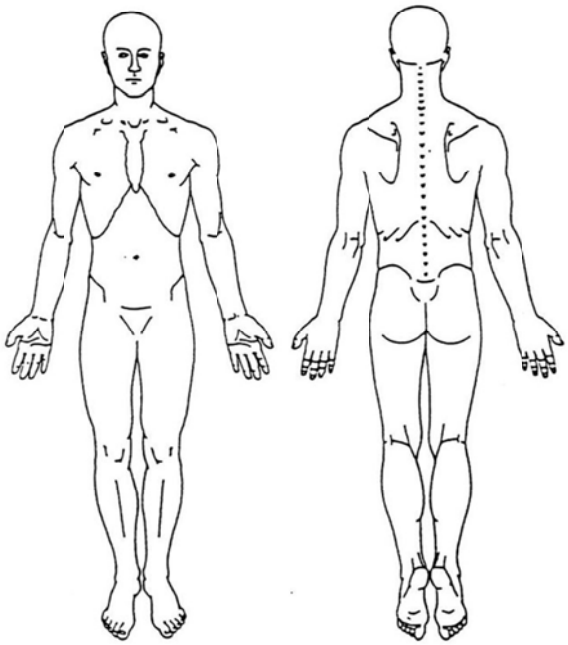
0= UNABLE to perform activity 10=Able to perform activity at same level as before injury

ACTIVITY: eg: unable to lift arm overhead	Score 0-10	Score 0-10	Score 0-10
1.			
2.			
3.			

DATE:

Body Diagram

Instructions:
On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pan that are not related to your present injury or condition,



For office use only: Height:_____ Weight:_____ Falls: Y/N Homecare: Y/N Other PT: Y/N