ProCare Physical Therapy

Name: _____

Reason for coming to physical therapy (chief complaint):_____

_____

When did this current problem first start?_____

Have you previously experienced this problem? No When?_____

Have you missed work/school due to this condition? No How much?_____

My condition since onset is: (circle one)	Better	Worse	Unchanged	Fluctuating
My discomfort is: (circle one)	Constant	Intermittent		
I feel **better** during: (circle one)	Morning	Midday	Evening	Night
I feel **worse** during: (circle one)	Morning	Midday	Evening	Night

Please rate your pain on a scale of 0-10: (0= no pain, 10= severe pain, intolerable)

Currently: _____ At best: _____ At Worst: _____

What activities/positions **increase or aggravate** the pain? (specific) _____

_____

What activities/positions **decrease or relieve** the pain? (specific) _____

_____

My typical activity level is: (place an x along the continuum):

Sedentary **<**_____**>**Extremely Active

Goals you wish to achieve in physical therapy: _____

_____

19033 E. Plaza Drive Parker, CO 80134 * Phone 303-805-4497 * Fax 303-805-3937