SOUTH BOISE PHYSICAL THERAPY

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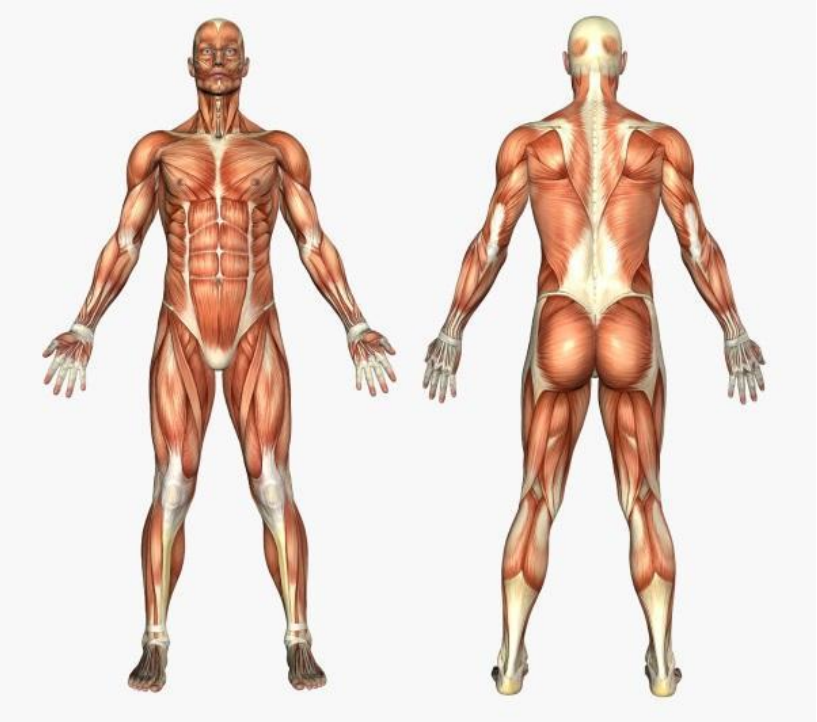
Name: _____ Date: _____

1. What is your injury? _____
2. How did your injury begin? _____
3. How long ago did it begin? _____
4. What is your type of work? _____
5. Are you working? ..... YES NO
   If no, is it because of your problem? ..... YES NO
6. Before this injury were you completely free of symptoms? ..... YES NO
7. Have you ever had anything similar before? ..... YES NO
8. What, if any, treatments have you had for this current problem?
   Physical Therapy Chiropractic Medical Other
9. What eases your pain? ..... Sitting Standing Walking Lying down
10. What makes your pain worse? ..... Sitting Standing Walking Lying down
11. Describe your pain (circle one)

    Numbness/tingling Dull/achy Sharp/piercing Throbbing

12. Pain scale (circle one): 1=very mild/no pain, 10=agonizing
    1 2 3 4 5 6 7 8 9 10
13. Do you have any other problems? ..... YES NO

14. Please circle on the body figure the places of discomfort:



Are you taking any medications? YES NO

What kind?

_____

_____

If you carry a list, please let us make a copy for your records.