

Patient Symptom Rating Form-Initial Visit



Patient Name: _____

Today's Date: _____

Date of Birth: _____

Therapist: _____

Referring Physician: _____ Date Problem/ Injury Began: _____

Describe your injury: _____

What makes the problems **worse**? _____

What makes them **better**? _____

Current Medications: _____

Pain Rating: On a scale of **0 (no pain)** to **10 (worst pain ever)**?

At Present:	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At its Worst:	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At its Best:	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On Average: PAST WEEK	0	1	2	3	4	5	6	7	8	9	10
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please mark location and type of pain.

- Numbness

- Pins & Needles
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- Burning
XXXXXX
- Stabbing
////////
- Aching
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