PHYSICAL THERAPY/BALANCE THERAPY FORM

Name:_____ Date:_____

What is your chief complaint? _____

When did it start?_____

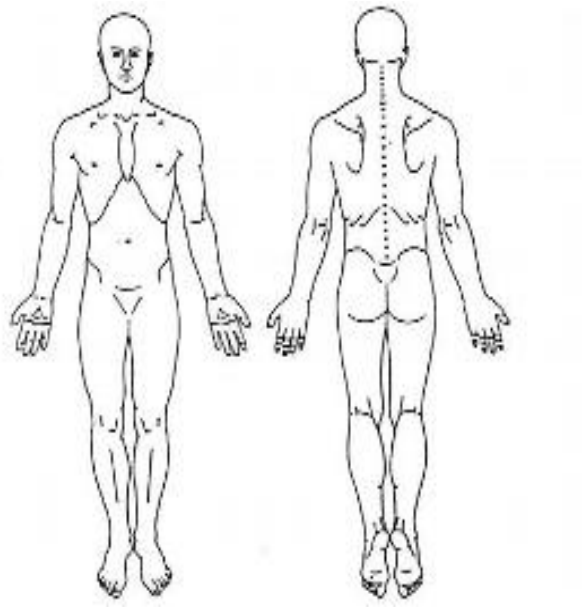
Is it due to an injury, fall, or accident? _____

Is your condition resulting in a worker's compensation claim? _____
If so, is a lawyer involved? Yes No

Have you had any other treatments for this condition (currently or in the past)? Yes No
Please explain _____

If balance is an issue, have you fallen? Yes No
If yes, how often have you fallen in the past week: _____ or month: _____or year:_____
Do you have dizziness? Yes No _____

PAIN SCALE:



If you are experiencing pain, please mark on the diagram to the left where you are experiencing pain.

On a scale of 0- 10 (0= no pain, 10=emergency room pain), how would you rate your pain:
Now: _____ At worst: _____ At best: _____

Circle the items that describe the nature of your pain:

sharp	dull	piercing	shooting
aching	deep	superficial	tingling
burning	numb	intermittent	constant
stabbing			

What makes your pain worse _____

What makes it better _____

Is your pain: improving worsening constant

Is there anything else that you feel we should know about to give you quality care? _____
_____

So we can best serve you, please list your goals for therapy _____
_____

Signature of Patient/Guardian _____ Date: _____

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