FARM TO TREATMENT TABLE
LOCALLY GROWN PHYSICAL THERAPY

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 ☐
At its Worst:	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
At its Best:	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐
On Average: ***PAST WEEK***	0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	5 ☐	6 ☐	7 ☐	8 ☐	9 ☐	10 ☐

Please mark location and type of pain.

Numbness
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Pins & Needles
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Burning
XXXXX

Stabbing
//////////

Aching
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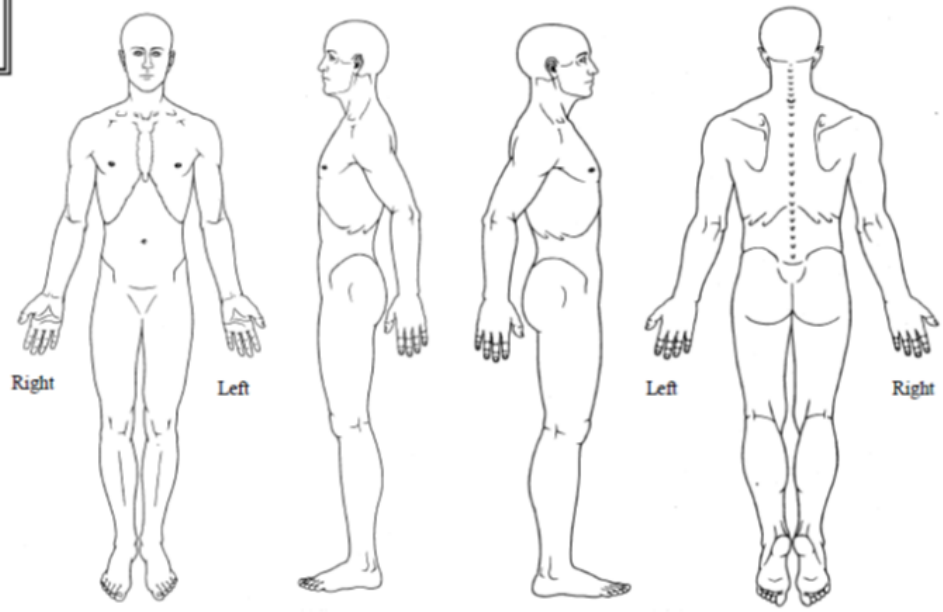

Rev. 12/2009