GREAT DIVIDE
PHYSICAL THERAPY

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SYMPTOM FORM

NAME: _____ **DATE:** _____

List of current symptoms: _____

_____

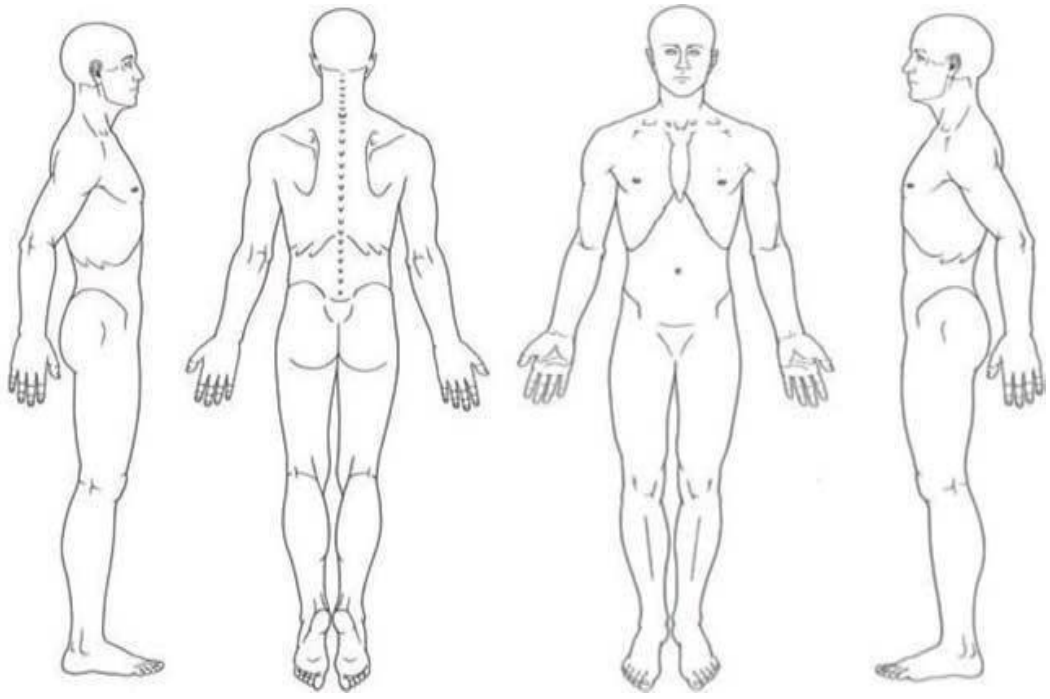
_____

Injury or Symptom Onset Date: _____

Injury Cause: ☐ **Auto Accident** ☐ **Workman's Comp Injury** ☐ **Other (Describe)** _____

Referring physician: _____ **Other referring source:** _____

On the picture below, please mark the location of the symptoms:



Please circle any of the following words that describe the symptoms:

Sharp	**Stabbing**	**Burning**	**Ache**
Tingling	**Numb**	**Other (Describe)** _____	

My symptoms currently: ☐ **Come and go** ☐ **Are constant** ☐ **Change with activity**

Circle your current average pain level: 0 . . 1 . . 2 . . 3 . . 4 . . 5 . . 6 . . 7 . . 8 . . 9 . . 10

Please identify the goals you would like to achieve: _____

_____