

Southside Physical Therapy

364 SE Wilson Ave.
Bend, OR 97702
(541)388-2681

Date _____

Name _____ Date of Birth _____

Occupation _____ Work Type: Sedentary ____ Light Manual ____ Heavy Manual ____

Age _____ Height _____ Weight _____ Primary Care Physician _____

Please List all Current Medications: _____

Please List Previous Surgeries, Major Illnesses and Current Medical Conditions: _____

Pain Rating – Rate your pain levels using the scale below, to indicate the intensity of your pain.

Your Pain	0-10 SCALE OF PAIN SEVERITY	
(during the last 30 days use pain scale on the right.)	Severity	Description of experience.
	0	No Pain Pain Free.
	1	Minimal Pain is hardly noticeable.
Pain Rating at this moment _____	2	Mild Feel a low level of pain; aware of pain only when paying attention to it.
	3	Uncomfortable Pain is troubling but can be ignored most of the time.
	4	Moderate Constantly aware of the pain but can continue normal activities.
Best: (least amount of pain) _____	5	Distracting Pain is barely tolerable; some activities limited by pain.
	6	Distressing Pain preoccupies thinking; must give up many activities due to the pain.
	7	Unmanageable Constant pain that interferes with almost all activities; often must take time off work; nothing seems to help.
Worst Pain: (during last 30 days) _____	8	Intense Severe pain makes it hard to concentrate on anything but the pain; conversation difficult.
	9	Severe Can concentrate on nothing but the pain; can do almost nothing; can barely talk.
	10	Immobilizing Pain is excruciating. Unable to move except to seek immediate help for pain in emergency room. Bedridden.
	KP Northwest	

List three functional activities or positions most limited by this episode:

(Eg: Sitting, sleeping, standing, walking, lifting, fixing your hair, getting up from a chair, putting on shoes or pants, getting in and out of a car, turning over in bed, etc.)

1. _____

2. _____

3. _____

Please complete the Symptom diagram on the reverse side. Thank you.