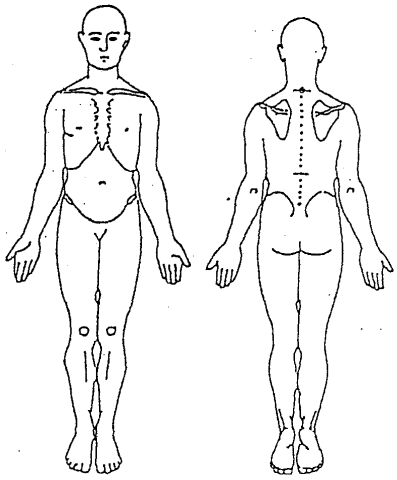
Patient Name _____ Patient Number_____

Focus Physical Therapy

1. What is the goal you hope to achieve with therapy and why?

2. Do you have concerns about therapy?

3. Where is your pain?
   Please mark on the drawings below the areas where you feel your pain.



Pain Scale: Please circle your pain on the lines below.

Family/ Home Responsibilities

(No pain) 1 2 3 4 5 6 7 8 9 10 (max pain)

Recreation

(No pain) 1 2 3 4 5 6 7 8 9 10 (max pain)

Social Activity

(No pain) 1 2 3 4 5 6 7 8 9 10 (max pain)

Occupation

(No pain) 1 2 3 4 5 6 7 8 9 10 (max pain)

Sexual Behavior

(No pain) 1 2 3 4 5 6 7 8 9 10 (max pain)

Self-care

(No pain) 1 2 3 4 5 6 7 8 9 10 (max pain)

Exercise

(No pain) 1 2 3 4 5 6 7 8 9 10 (max pain)

Sleep

(No pain) 1 2 3 4 5 6 7 8 9 10 (max pain)