ProActive Physical Therapy, LLC

"Be ProActive, Not ReActive"

Current Condition

Name: _____ **Date**: _____

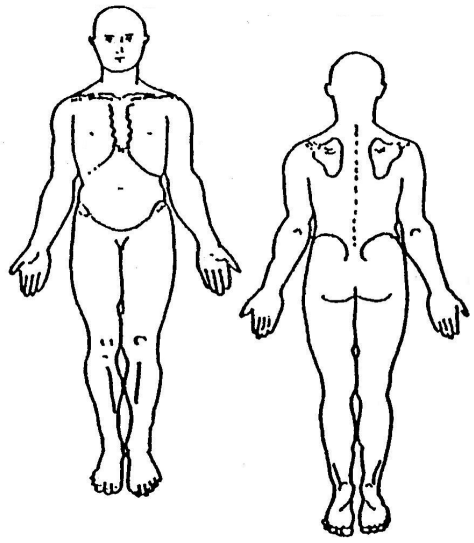
Primary problem: _____

How and **when** did injury occur: _____

Referring physician: _____
Does ProActive Physical Therapy LLC have permission to report your progress this doctor? Yes No
How did you hear of us if different than your physician? _____

Pain Scale: (0 = no pain; 5 = moderate pain; 10 = extreme pain)
Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10
Best pain rating: 0 1 2 3 4 5 6 7 8 9 10
In the past month have you been getting: Better Worse Same

Indicate your symptoms on the body below using the following KEY:
X = pain
O = numbness or tingling



Please identify three activities that you are unable to do or are having difficulty with as a result of your injury and score activities based on activity score scheme (0 -10 Scale: 0 = unable to perform activity and 10 = able to perform activity to the same level as before injury or problem).

Activity:	**Score (0 – 10):**
_____	_____
_____	_____