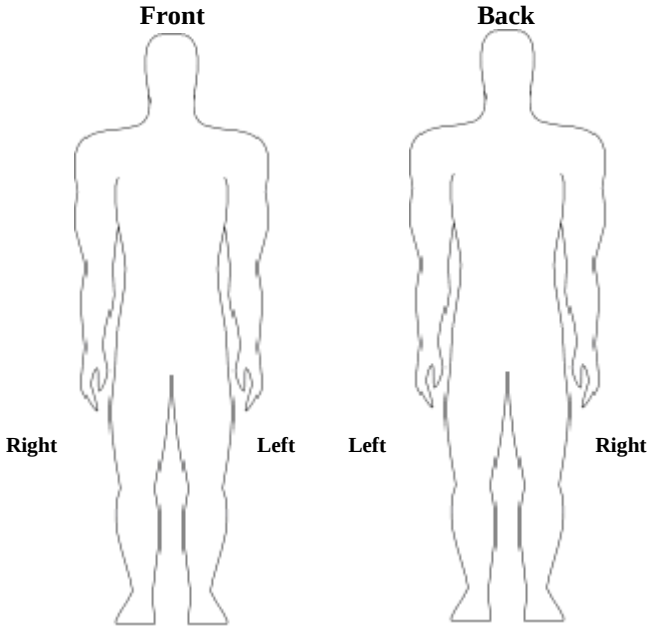
South Whidbey Physical Therapy
& Sports Clinic

Initial Evaluation – *Patient to fill out*

Name: _____ Age: _____ Date: _____

Please mark the location of the pain/problem you are currently being seen for on the body chart below: (If more than one area, please mark area 1, 2, etc.)



Please rate your pain

0 = None 5 = Moderate 10 = Extreme

Pain Location: _____

	0	1	2	3	4	5	6	7	8	9	10
At Worst:	○	○	○	○	○	○	○	○	○	○	○
Current:	○	○	○	○	○	○	○	○	○	○	○
At Best:	○	○	○	○	○	○	○	○	○	○	○

Pain Description:

□ burning □ sharp □ dull/achy □ throbbing □ shooting □ numbness/tingling
□ constant □ intermittent □ worse in AM □ worse in PM □ worse at night
□ other: _____

Aggravating Factors:

□ sitting □ standing □ walking □ stairs – up □ stairs - down □ sit to stand
□ bending □ voiding □ lying down □ cough/sneeze □ other: _____