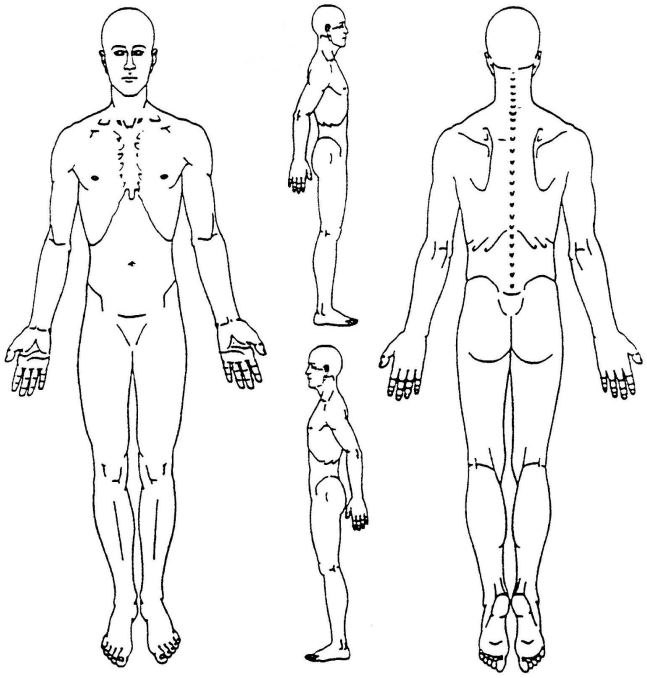
WARRIOR KINETICS
PHYSICAL THERAPY
DR. EMILY TA, PT, DPT, CSCS

Patient Name: _____
Date of Birth: _____ Age: _____ Gender: ☐ Male ☐ Female
Phone Number: _____ Email: _____
Address: _____ City: _____ Zip Code: _____
Emergency Contact: _____ Emergency Phone: _____
Referring Physician/Person: _____

Chief complaint/injury: _____
_____
Cause of pain/injury: _____
_____
Date of pain/injury onset: _____ Onset: ☐ Gradual ☐ Sudden
Since the initial onset, the symptoms have gotten: ☐ Better ☐ Worse ☐ Same
Imaging or tests performed? ☐ None ☐ X-ray ☐ MRI ☐ CT scan ☐ Other _____
Results (if applicable): _____
Symptoms are worsened by: _____
Symptoms are improved by: _____
Current health conditions: _____
Past medical health conditions and/or surgeries: _____

Please use the diagram below to mark where your current symptoms are:



Symbols:

Dull/Aching △ △ △	Burning x x x
Stabbing / / /	Radiating > > >
Tingling + + +	Numbness ~ ~ ~

Current symptoms are:
☐ Constant ☐ Intermittent ☐ Chronic

Pain severity scale (circle a number):
0 = no pain, 10 = worst pain imaginable

Current level of pain:
0 1 2 3 4 5 6 7 8 9 10
Best level of pain in the past week:
0 1 2 3 4 5 6 7 8 9 10
Worst level of pain in the past week:
0 1 2 3 4 5 6 7 8 9 10

Signature: _____ Date: _____