COASTAL REHAB

PHYSICAL THERAPY + SPORTS + SPINE

Symptoms began on: ____________________

1. Briefly describe your symptoms:

____

____

____

2. How did your symptoms start?

____

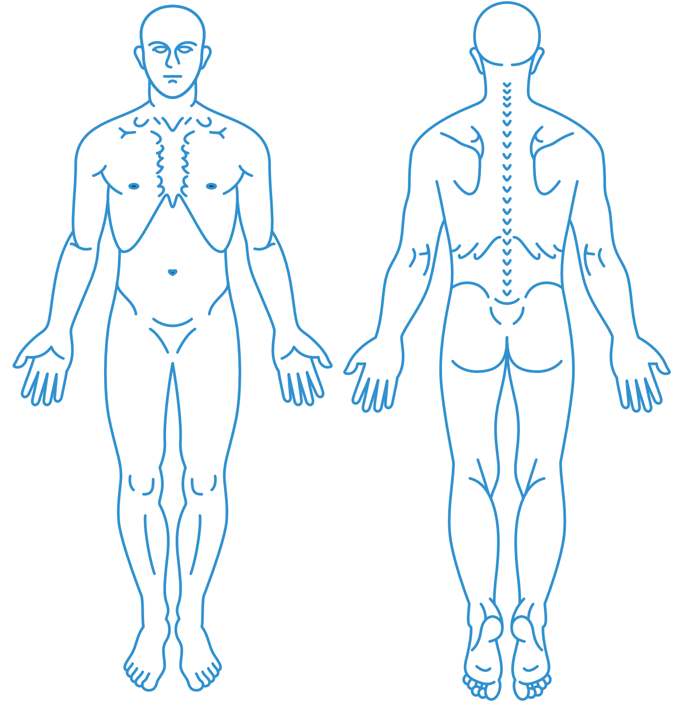
____

____

3. Average pain intensity:

	NO PAIN									WORST PAIN
Last 24hrs	1	2	3	4	5	6	7	8	9	10
Last Week	1	2	3	4	5	6	7	8	9	10

Indicate where you have pain or other symptoms:



4. How often do you experience your symptoms?

1. Constantly (76%-100%)
2. Frequently (51%-75%)
3. Occasionally (26%-50%)
4. Intermittently (0%-25%)

5. How much have your symptoms interfered with your usual activities?

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

6. How is your condition changing, since care began at this facility?

1. Much worse
2. Worse
3. A little worse
4. No change
5. A little better
6. Better
7. Much better

7. In general, would you say your overall health right now is?

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

Patient Name: ______________________________

Patient/guarantor Signature: ______________________ **Date:** ____________

E | info@coastalrehabnc.com **P** | 252.338.2114 **F** | 252.338.2115