PHYSICAL THERAPY SERVICES

Patient Questionnaire

Please describe the location of your problem: _____

If you have pain, please describe**:** _____

Rank your pain on a scale of 1 to 10, with 10 being terrible: _____

Please describe what activities you cannot do because of your problem: _____

What activities can you do, however require assistance: _____

_____

Other Medical Problems:_____

Recent Hospitalizations: _____

Medications: _____

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