WHEN PAIN IS NOT YOUR COMPLAINT

Please briefly describe your primary concerns: (I.e. strength, balance, continence, coordination etc.)

_____

_____

_____

_____

When did the symptoms begin? Have you had them before?

_____

_____

How did the symptoms start? Do you know what caused them?

_____

_____

_____

What are your goals with treatment?

_____

_____

_____

_____

Have you had Physical Therapy for this condition? Did it help?

_____

_____

Additional information that may help us to help you.

_____

_____

_____

_____

SIGNATURE DATE