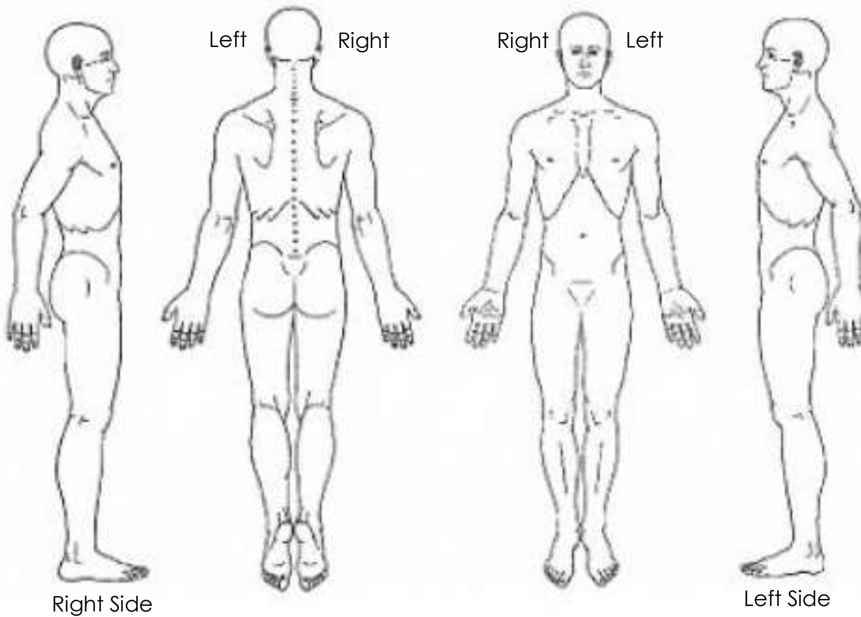
ADVANCED CARE
Physical Therapy

300 S. 1st Street
Houston, MO 65483

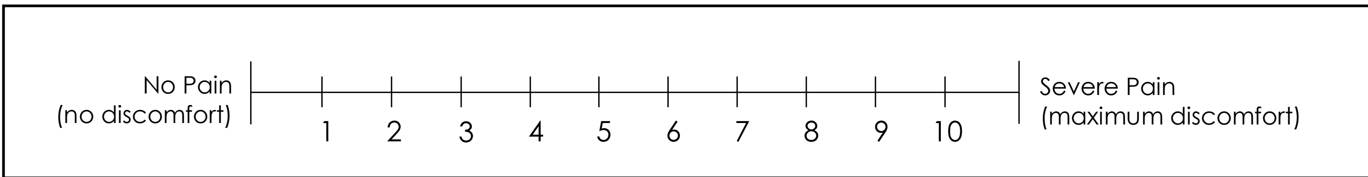
Phone: **(417) 967-0900**
Fax: (417) 967-0905

Name: ___________________________________ Date: _________________________

Please fill in your area(s) of discomfort / symptoms. Do not use circles or X's. Instead, color in the area(s) with a pen, as if you were drawing in a children's coloring book. Be as precise as you can about the exact area the symptoms occupy and what their boundaries are. Write in descriptive words where the necessary (dull, sharp, better, worse, numbness, tingling, etc.). This form is a tool for you to communicate with us about process and changes in your condition.



Rate your pain: Please make an X mark on the line below which corresponds to the degree of your present pain. This value will be measured and charted on a graph to help us keep track of how you are progressing.



Affective Scale: On the next line please make an X mark corresponding to the degree of functional limitation you experience as a result of the symptoms we are treating you for. Essentially, the question you are answering here is, **"How much is your problem limiting what you do?"**