Grant/Spangle
PHYSICAL THERAPY

Patient name: _____

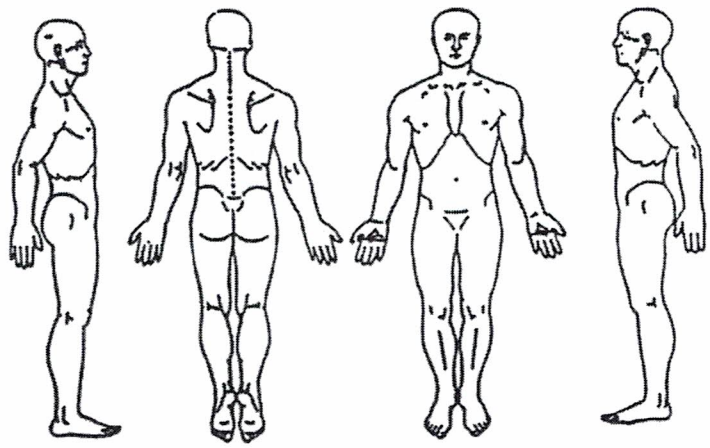
Symptoms resulting from: ☐ accident ☐ fall ☐ surgery ☐ overuse ☐ unknown Height: _____

Date of onset:_____ Weight: _____

Chief complaint at present:_____

Chief complaint at onset:_____

Mark location of symptoms on diagram below.



Symptoms: check the appropriate box

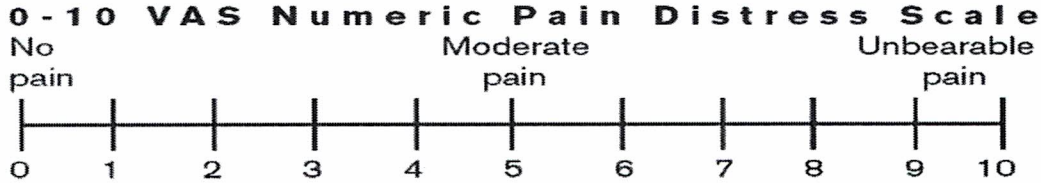
☐ leg weakness	☐ bowel/bladder problems	☐ tingling	☐ trouble sleeping
☐ arm weakness	☐ pain with coughing/sneezing	☐ jaw pain	☐ headache
☐ dizziness	☐ ringing in ears	☐ pain	☐ fatigue
☐nausea	☐ sinus ache	☐ numbness	

Is your pain: ☐ sharp ☐ dull ☐ burning ☐ achy ☐ shooting

Name 3 symptoms from above and rate the intensity (as mild, moderate, or severe) and how long this has occurred.

1._____
2._____
3._____

What aggravates your symptoms?_____

What relieves your symptoms?_____

Please mark on the scale below your pain level.