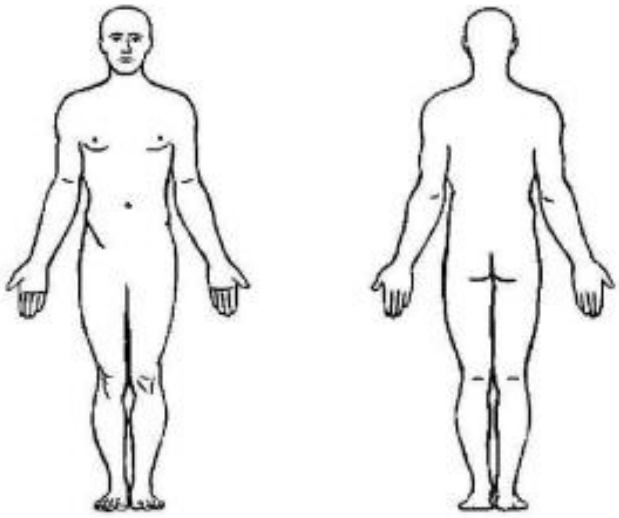
BATON ROUGE PHYSICAL THERAPY

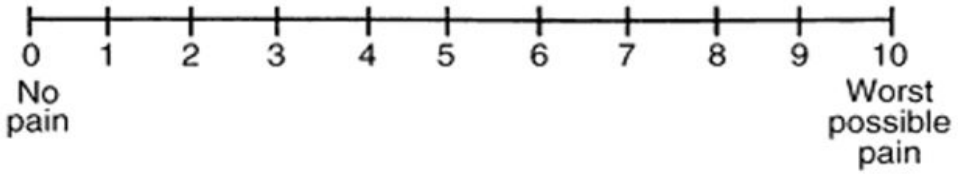
Patient name:	DOB:
Symptom Rating	

Mark location of symptom(s): **O - For pain**
X - For numbness/tingling/burning

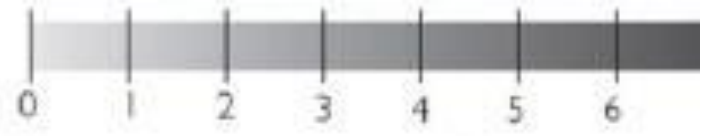


Please rate your pain - on a scale from 0 – 10 (0 = No Pain; 10 = Worst pain imaginable)

Current: / 10	Best: / 10	Worst: / 10



Please rate your level of agreement on the scale below - "I should not do physical activity which (might) make my pain worse".



0 = **Disagree** **3 = Unsure** **6 = Agree**

Signature: _____ Date: _____