REHABILITATION& Performance Center

PHYSICAL THERAPY

Patient Name:_____ Date:_____

Dear Patient:

If you currently feel or have felt any of the following symptoms within the past month if you have been diagnosed with any of the following conditions, please check the appropriate boxes.

This is a screening tool that can help your Therapist what diagnostic tests may be appropriate for you. Please check all that apply:

	Low Back and Radiating Pain		Neck Pain and Radiating Pain
	Numbness, Tingling, or Burning Sensation in the Legs or Feet		Numbness, Tingling, or Burning Sensation in the Arms or Hands
	Weakness in the Arms or Legs		Loss of Sensation in the Hands/Feet
	Diabetes or Neuropathy		Shoulder Pain Disability
	Tendinitis/ Bursitis/ Arthritis		Wrist-Hand Pain or Instability
	Elbow Pain or Instability		Ankle-Foot Pain or Instability
	Hip Pain or Instability		Headaches
	Knee Pain or Instability		History of Falls due to Dizziness
	Dizziness or Vertigo		Unsteady Gait
	None of the above apply		

Patient Signature:_____