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Current Condition

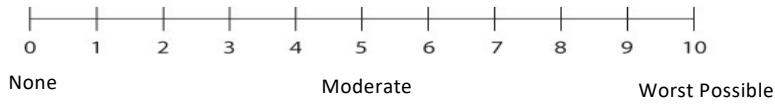
Name: _____ Date: _____

When did the injury or illness start? ___ / ___ / ___
Month Day Year

What was the cause of your current condition: _____

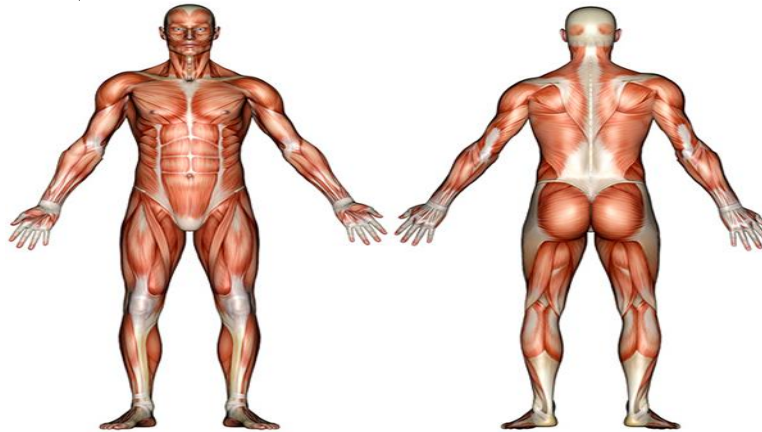
Please describe your current symptoms: _____

According to the scale below, rate your symptoms over the past week.



Current: _____ Worst: _____ Best: _____

Please mark where you are experiencing your symptoms:



Better With: (check all that apply)

- Sitting
- Bending Forward
- Sit to Stand
- Lying on Side
- Morning
- Rest
- Stairs
- Pain Medicine
- Other: _____
- Standing
- Bending Backward
- Walking
- Lying Flat
- Evening
- Movement
- Stretching
- Heat/Ice

Worse With: (check all that apply)

- Sitting
- Bending Forward
- Sit to Stand
- Lying on Side
- Morning
- Rest
- Stairs
- Pain Medicine
- Other: _____
- Standing
- Bending Backward
- Walking
- Lying Flat
- Evening
- Movement
- Stretching
- Heat/Ice

Please list any functional activities or movements that you are limited with: _____

What do you hope to attain through Physical Therapy: _____
