

Client Reevaluation Questionnaire (to be completed every 4-6 weeks)

What changes have you noticed over the past 4-6 weeks? _____

What can you do now that you couldn't do before starting Physical Therapy? _____

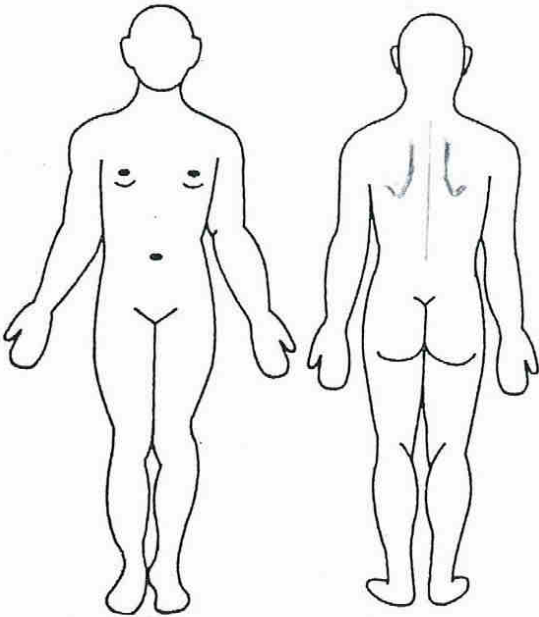
What are you currently doing for yourself? _____

What, about you, is your biggest concern right now? _____

Please indicate on the scale below, the intensity of your symptoms:

0 1 2 3 4 5 6 7 8 9
none mild very uncomfortable distressing severe intolerable

Please indicate on the figures below, the area(s) in which you are experiencing symptoms:



Also, please list your most painful areas, and rate them using the 0-9 scale above:

Area (1) _____

Usual pain level:

Lowest level:

Highest level:

% of time at highest pain level: _____

% Improvement since started PT: _____

Area (2) _____

Usual pain level:

Lowest level:

Highest level:

% of time at highest pain level: _____

% Improvement since started PT: _____

Area (3) _____

Usual pain level:

Lowest level:

Highest level:

% of time at highest pain level: _____

% Improvement since started PT: _____

Please rate each of the following on a positive scale of 0-9; "9" being the highest or most positive rating and "0" being the lowest or worst rating.

1. Health _____
2. Well-being _____
3. Energy level _____
4. Freedom from Tension _____
5. Knowledge of your body _____
6. Ability to deal with stress _____
7. Freedom from pain _____

Measured Height: _____

Do you feel you need to continue Physical Therapy? Yes No If yes, what gains do you hope to make if you continue? _____

Patient Name: _____

Date: _____