PINNACLE
PHYSICAL THERAPY

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COLLABORATION HEALING QUALITY Recovery WINS TEAM COMMUNITY SUCCESS

Discovery Consultation

Please Complete Before Your Visit

- **Name:** _____
- **Email:** _____
- **Today's date:** _____
- **Body part(s) or diagnosis:** _____
- **When did symptoms begin?** _____

- **How's your overall health?** (Circle One)
  Excellent • Good • Fair • Poor • Very Poor
- **How was your function pre-injury?** _____%
- **How's your current level of function?** _____%
- **Is your overall condition:** (Circle One)
  Improving • Getting Worse • Staying the Same

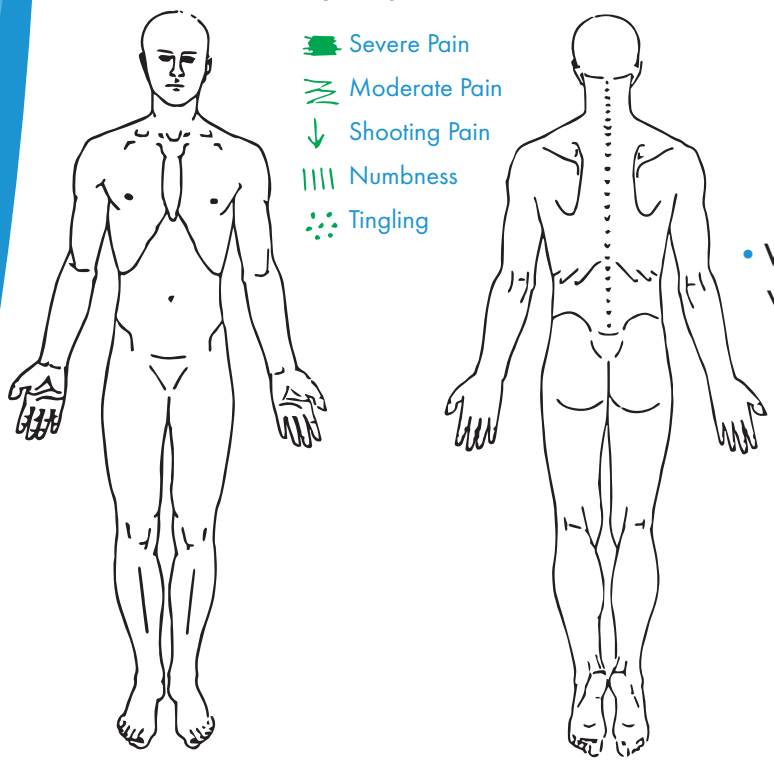
- **Rate your pain:** (0 - No Pain to 10 - Worst Imaginable)
  Current Pain (0 to 10): _____
  At Best (0 to 10): _____
  At Worst (0 to 10): _____

- **What eases your symptoms?**
  - ○ Moist Heat
  - ○ Rest
  - ○ Ice
  - ○ Change in Position
  - ○ Medication
  - ○ Other: _____

- **Have you received any of the following tests for this problem?**
  - ○ X-Rays
  - ○ Bone Scan
  - ○ MRI
  - ○ EMG
  - ○ CT Scan
  - ○ Nerve Conduction Study
  - ○ Other: _____

- **Which activities increase your symptoms?**
  - ○ Bending
  - ○ Reaching
  - ○ Squatting
  - ○ Driving
  - ○ Walking
  - ○ Stairs
  - ○ Kneeling
  - ○ Rising
  - ○ Standing
  - ○ Lifting
  - ○ Sitting
  - ○ Twisting
  - ○ Other: _____

- **Please draw where your pain is:**



- **Circle any pain descriptions that apply below:**

Aching	Numbness	Catching
Stabbing	Pins & Needles	Burning
Shooting	Dull	Tingling
Throbbing	Radiating	Sharp

- **What would you like to address with today's visit?:** _____