***RS* PHYSICAL THERAPY**

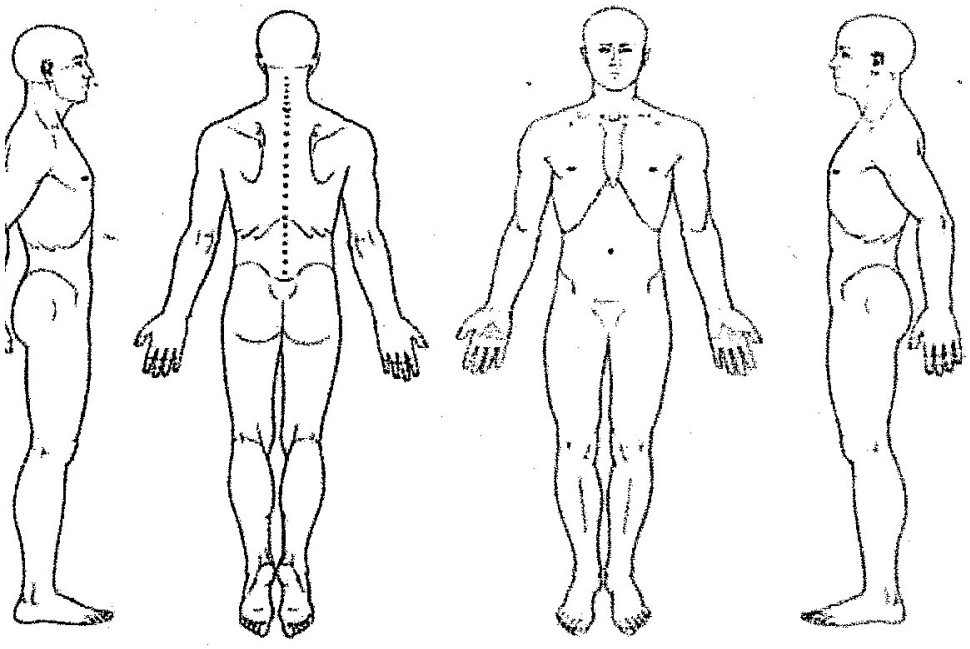
Patient Name: ---------- Date: ----------

Do You have pain at rest : **Yes or No**

Do you have pain during activity : **Yes or No**

Does the pain interfere with your daily activities **Yes** or **No**

Please mark on the picture anyplace that you are having **XXXX** for **Pain, oooo** for **Numbness**, ------- **for Tingling Sensation** and **///// for Burning**



What is your current pain level?

0___1____2____3_____4_____5____6____7____8____9____10

No Pain Worst