MAXX
PHYSICAL THERAPY

FREE Pain Screen

Name: _____ Date: _____

Location(s) of Pain: _____ DOB: _____

Approximately how long have you had this pain? _____ years - months - weeks

On a pain scale of 1-10 (1= mild discomfort; 10 = extreme pain), how would you rate it

right now? _____ at its best? _____ at its worst? _____

What increases your pain? *(Certain movements, activity, time of day, etc)* _____

_____

Does the pain negatively impact your sleep? _____ work? _____ life? _____

Have you had any other types of services for this injury/episode: YES NO

If so, what? *(i.e., x-rays, MRI, EMG, etc)* _____ Date: _____

Did you have surgery for this injury? YES NO

If yes, type of Surgery: _____ Date: _____

Other Surgeries: _____

Is an attorney involved? YES NO

Anything else we should know? _____

_____

_____

We look forward to making you awesome again!

337.508.2505 office 337.508.2506 fax info@maxxpt.com