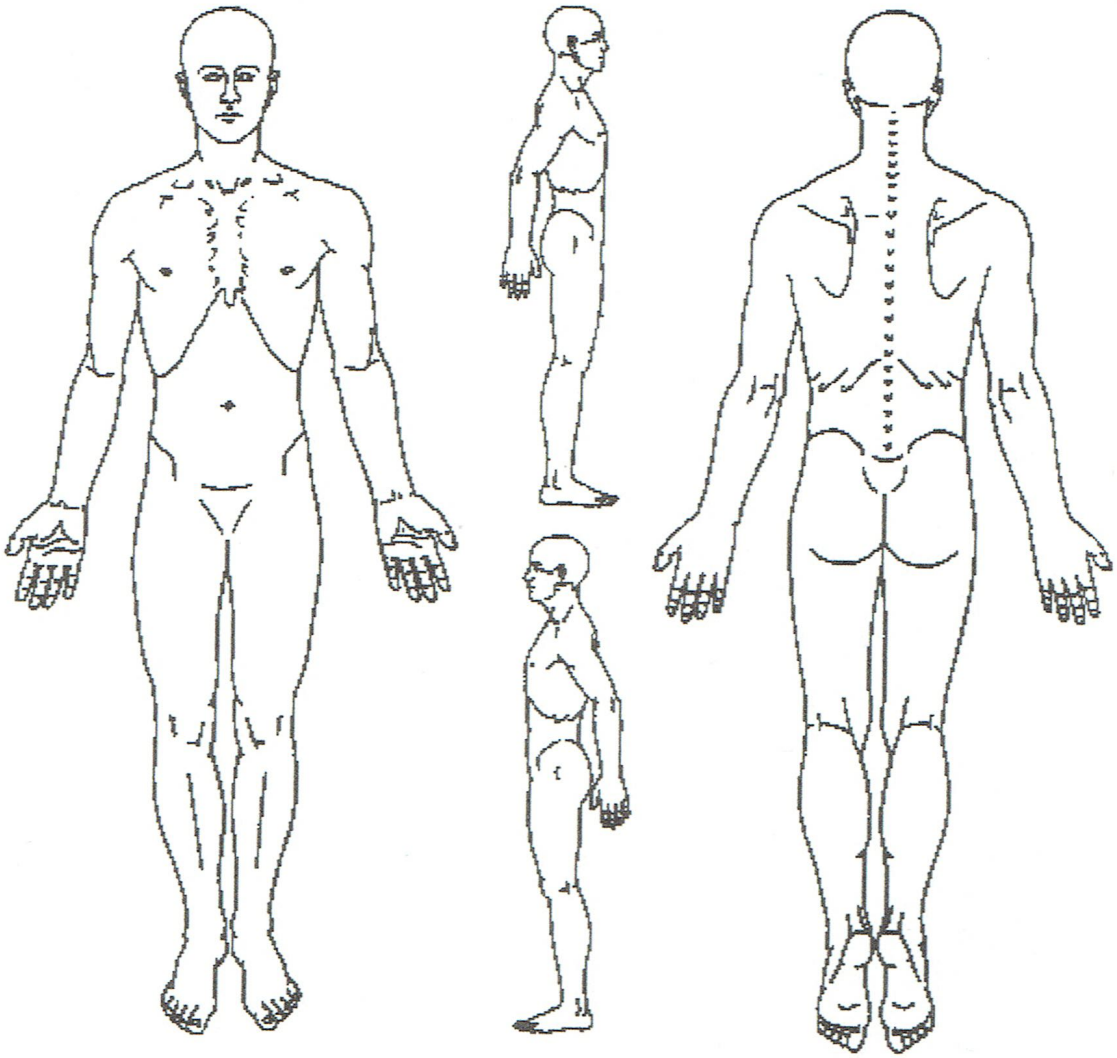
REVOLUTION PHYSICAL THERAPY NYC

Name: Age: Date:

Please mark the area(s) on the body diagram that correspond to your symptoms.

X=pain
O= numbness/tingling
Z= other

Front **Back**



Circle the words which best describe your symptoms:

Dull/Ache	Sore	Gnawing	Sharp/Stabbing
Shooting	Heaviness	Burning	Tightening/Constricting
Awareness	Throbbing	Weakness	Other: _____

How long have you had your current problem?