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Name: _____ Date: _____

How do you prefer to be addressed? _____ Age: _____

Occupation: _____ Height: _____ Weight: _____

Address: _____

Phone: _____ E-mail: _____

How did you hear about us? _____

Referring Physician: _____

Address: _____

Phone/Fax: _____

Referring Therapist: _____

Address: _____

The following section is very important in my evaluation process.
Please answer each question as honestly as possible to provide me with a clear picture of your current symptoms, issues or general health goals.

1. What is your primary complaint?

2. Are there any other secondary complaints? If so, please describe below.

3. On what date did your symptoms begin? _____

4. How did your symptoms begin? *For example, did your symptoms begin as a result of an accident or trauma, or did they begin without a known reason?*

5. Have you ever received either of the following treatments for the condition(s) mentioned above? If yes, please indicate length of time and effectiveness.

   Physical Therapy:

   Myofascial Release and Pelvicology:

6. By placing a slash on the line below, please indicate the level of ***intensity*** of your symptoms at this time.

   None ----------Worst Possible

7. What activities make your symptoms worse?

8. What activities make your symptoms better?

9. On the line below, please mark your daily-functional-ability based on percentage.

   On a “good day” - 0% ----------100%

   On a “bad day” - 0% ----------100%

10. Please indicate the area(s) of concern on the image below.