

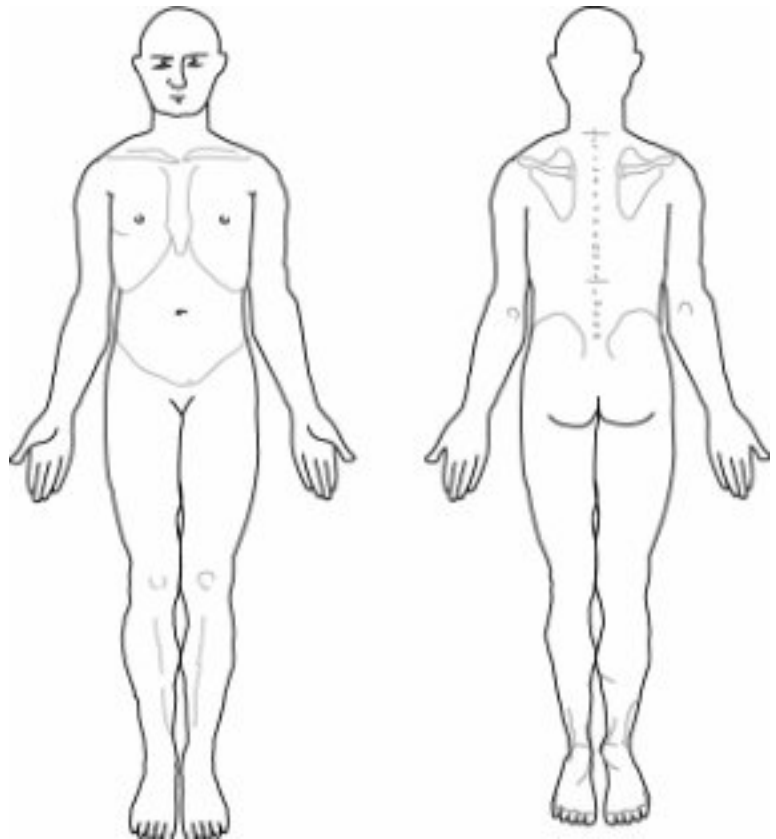
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Patient Assessment Form

NAME: _____ **DATE:** _____

This form contains a series of questions designed to help your Physical Therapist evaluate your condition, track how you feel, and determine how well you are able to do your usual activities. This information will help your therapist and referring physician give you the best possible care. Please answer every question as accurately and completely as you can.

- 1) What are your symptoms? Localize areas of pain or abnormal sensation on the body chart below. (Shade in where appropriate.)



- 2) Was the onset of this episode gradual or sudden (Check one)

Gradual

Sudden

- 3) How long has this episode of symptoms lasted with symptoms occurring at least part of every day?

Less than 1 week

6 weeks – 3 months

Greater than 1 year

1 – 6 weeks

3 months – 1 year

- 4) When did you first notice this episode of symptoms (please indicated a date if possible)?