

Canyon Physical Therapy and Aquatic Rehabilitation Re-evaluation Questionnaire

Name _____ Date _____ Visit # ____/____

Date of most recent Dr's visit _____ and date of future Dr's appointment _____.

Please place a **B** on the pain rating scale below for your pain level at its best within the last three days and place a **W** on the scale for your pain at its worst in the last three days.

No Symptoms _____ Worst it could be
0 1 2 3 4 5 6 7 8 9 10

Do you have pain... less often just as often more often

How has your activity tolerance changed?

- Much improvement
- Moderate improvement
- Slight improvement
- No improvement

How has your use of pain, anti-inflammatory, or other related medications changed?

- Decreased
- No change
- Increase
- Not using medications related to this problem.

With what activities are you still having difficulty with? _____

How would you rate your progress with your goals for Physical Therapy (0%-100%). _____

How would you rate your return to your prior level of function (0%-100%). _____

I am satisfied with my ability to complete my activities of daily living.

- Strongly Agree Agree Neutral Disagree

I feel that I am ready to manage my condition/symptoms on my own.

- Strongly Agree Agree Neutral Disagree

What is your overall satisfaction with your care and customer service at Canyon Physical Therapy and Aquatic Rehabilitation (0%-100%)? _____

Comments: _____
