

## Outcomes Research

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please make **ONE** mark on each line indicating your level of the following:

Example \_\_\_\_\_|\_\_\_\_\_

What is your level of limitation of activities? (Example: Walking, Dressing, Recreational, Sitting, Driving)

\_\_\_\_\_

*No Limited Activities*

*Severely Limited Activities*

What is your level of pain?

\_\_\_\_\_

*No Pain*

*Severe Pain*

What is your level of symptoms? (Example: Numbness, Tingling, Stiffness, etc.)

\_\_\_\_\_

*No Symptoms*

*Severe Symptoms*

*For Office Use Only:*

Initial Evaluation/Discharge # of Visits: \_\_\_\_\_

Therapist: \_\_\_\_\_