



ALTA PHYSICAL AND COMPLEMENTARY THERAPIES

Name: _____ Date: _____

WHERE IS YOUR PAIN?

Please mark on the drawings below the areas where you feel pain.

Functional Capacity

Please rate the following:

Pain Intensity (On a scale of 0 to 10; 10 = worst) _____

Activities of Daily Living (0-10; 0 unable, 10 fully able) _____

Occupational Tolerance (0-10; 0 unable, 10 fully able) _____

Recreational Tolerance (0-10; 0 unable, 10 fully able) _____

Please complete other side also. Thank you.