



Level Two Case Intake Form

Patient Name: _____ Handedness: _____ Date: _____

A: KEY COMPLAINTS: (Include measures for complaints; i.e. 0-10 scale for pain, 10 being most extreme, % limitation for Range of Motion, 0 – 10 scale for satisfaction with sleep, energy, mood, 10 being best possible). List considered points:		Check One:	
		Right	Left
1.			
2.			
3.			
B: FUNCTIONAL SUPPORT POINTS. NOTE: If not listed as a complaint, INCLUDE sleep, energy, mood here.			

