PHYSICAL THERAPY INITIAL EVALUATION FORM

PATIENT INFORMATION

DATE_____

NAME_____ OCCUPATION _____

(LAST) (FIRST)

BIRTHDATE _____ AGE _____ HEIGHT _____ WEIGHT _____lbs.

ADDRESS _____ PHONE NUMBER_____

_____ SSN _____

HOME/CELL PHONE _____ EMAIL _____

CURRENTLY EMPLOYED? ☐ YES ☐ NO ☐ MODIFIED EMPLOYER_____

STUDENT ☐ YES ☐ NO

MEDICAL INFORMATION (MARK ALL THAT APPLY) **THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART

☐ DIFFICULTY SWALLOWING	☐ MOTION SICKNESS	☐ STROKE
☐ ARTHRITIS	☐ FEVER/CHILLS/SWEATS	☐ OSTEOPOROSIS
☐ HIGH BLOOD PRESSURE	☐ UNEXPLAINED WEIGHT LOSS	☐ ANEMIA
☐ HEART TROUBLE	☐ BLOOD CLOTS	☐ BLEEDING PROBLEMS
☐ PACEMAKERS	☐ SHORTNESS OF BREATH	☐ HIV/HEPATITIS
☐ EPILEPSY/SEIZURES	☐ HISTORY OF SMOKING	☐ HISTORY OF ALCOHOL ABUSE
☐ HISTORY OF DRUG ABUSE	☐ DIABETES	☐ DEPRESSION/ANXIETY
☐ MYOFASCIAL PAIN	☐ FIBROMYALGIA	☐ PREGNANCY
☐ CANCER		

PREVIOUS SURGERIES: _____

OTHER: _____

REFERRING MD _____ DIAGNOSIS _____ SURGERY (Y) (N)

MEDICATIONS (PLEASE INCLUDE DOSAGES): _____

_____

IS YOUR INJURY/PAIN DUE TO (CIRCLE ONE): SPORT/SURGERY/FALL/CAR ACCIDENT/WORK RELATED/ INJURY/ABUSE

WORKERS COMPENSTATION? ☐ YES ☐ NO **NO FAULT (AUTO ACCIDENT)?** ☐YES ☐ NO

REHAB INFORMATION

1. CHIEF COMPLAINT/AILMENT/INJURY _____
2. DATE OF INJURY_____ DATE OF SURGERY _____
3. BRIEFLY DESCRIBE HOW YOU WERE INJURED_____

_____

4. HAVE YOU RECEIVED THERAPY FOR THIS CONDITION? ☐ YES ☐ NO WHEN? _____

HOW MANY VISITS _____

5. HAS YOUR CONDITION BEEN GETTING ☐ BETTER ☐ WORSE ☐ SAME
6. ARE YOUR SYMPTOMS ☐ CONSTANT OR ☐ INTERMITTENT

7. CIRCLE THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

AT BEST: 0 1 2 3 4 5 6 7 8 9 10 (EXCRUCIATING PAIN)

AT WORST: 0 1 2 3 4 5 6 7 8 9 10 (EXCRUCIATING PAIN)

8. WHAT DECREASES/MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

☐ BENDING	☐ MOVEMENT	☐ REST	☐ BETTER IN AM
☐ SITTING	☐ STANDING	☐ HEAT	☐ BETTER AS DAY PROGRESSES
☐ RISING	☐ WALKING	☐ ICE	☐ BETTER IN PM
☐ CHANGING POSITION	☐ LYING	☐ MDICATION	☐ N/A CAST JUST REMOVED

9. WHAT INCREASES/MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

☐ BENDING	☐ MOVEMENT	☐ REST	☐ SNEEZE
☐ SITTING	☐ STANDING	☐ STAIRS	☐ DEEP BREATH
☐ RISING	☐ WALKING	☐ COUGH	☐ MEDICATION
☐ PROLONGED POSITIONING	☐ LYING	☐ WORSE IN AM	☐ WORSE IN PM
☐ WORSE AS DAY PROGRESSES			

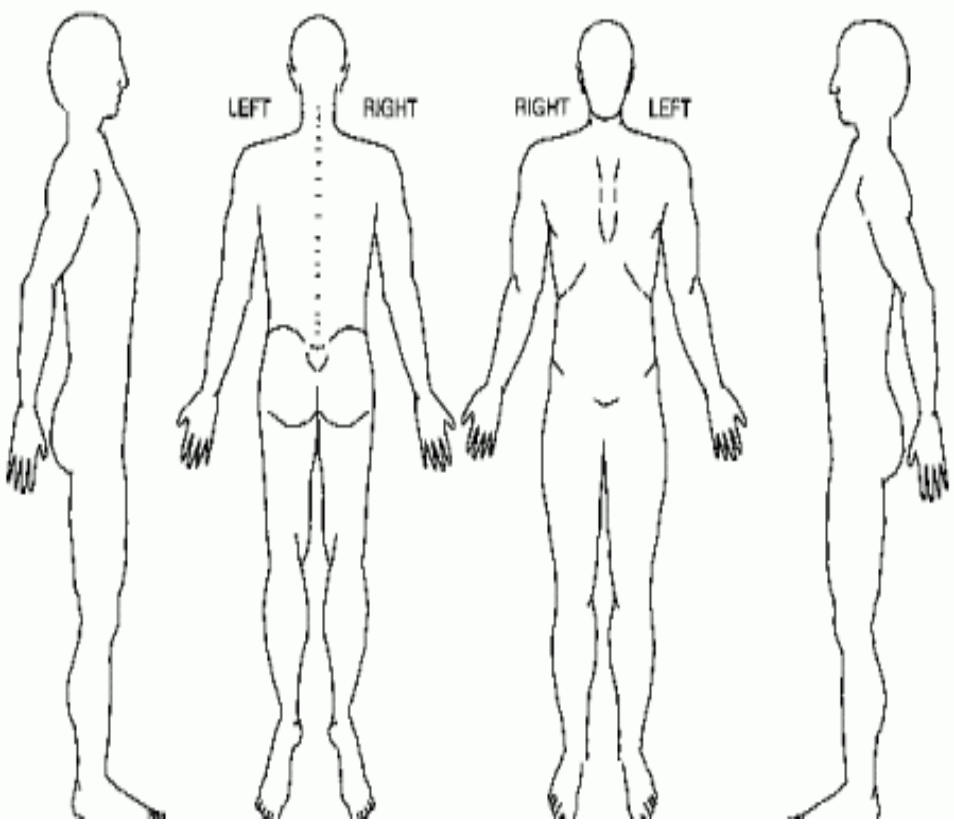
10. PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

☐ X-RAY/MRI ☐ CATSCAN ☐ INJECTIONS ☐ OTHER_____

11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY? _____

_____

DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS. If you are completing this form on the computer, print form after completion and mark the diagram with a pen.



SEVERE PAIN	*****
MODERATE PAIN	00000
DULL ACHE	!!!!!!!!
RADIATING PAIN	↓↑↓
NUMBNESS/TINGLING	XXXXX