PHYSICAL THERAPY INITIAL EVALUATION FORM

DATE________________

NAME____OCCUPATION _______________________

BIRTHDATE ________________ AGE _______ HEIGHT ________ WEIGHT _________lbs.

ADDRESS____

PHONE NUMBER______________________________

EMAIL _______________________________________

MEDICAL INFORMATION (PLEASE MARK ALL THAT APPLY)

THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART

- ☐ DIFFICULTY SWALLOWING
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART TROUBLE
- ☐ PACEMAKERS
- ☐ EPILEPSY/SEIZURES
- ☐ CANCER
- ☐ UNEXPLAINED WEIGHT LOSS
- ☐ BLOOD CLOTS
- ☐ SHORTNESS OF BREATH
- ☐ HISTORY OF SMOKING
- ☐ DIABETES
- ☐ FIBROMYALGIA
- ☐ STROKE
- ☐ OSTEOPOROSIS
- ☐ ANEMIA
- ☐ BLEEDING PROBLEMS HIV/HEPATITIS
- ☐ ARTHRITIS
- ☐ DEPRESSION/ANXIETY
- ☐ PREGNANCY

PREVIOUS SURGERIES (TYPE/BODY REGION/DATE):

____

____

MEDICATIONS (PLEASE INCLUDE DOSAGES):

____

____

INJURY INFORMATION

REFERRING MD (if applicable) ______________________________

CHIEF COMPLAINT/INJURY____

DATE OF INJURY____________________________

DATE OF SURGERY (if applicable)______________________________

BRIEFLY DESCRIBE HOW YOU WERE INJURED____

____

HAVE YOU RECEIVED THERAPY FOR THIS CONDITION? YES ☐ NO ☐

IF YES, WHEN? _________________

IF YES, HOW MANY VISITS _______________________________

HAVE YOU RECEIVED ANY INJECTIONS FOR THIS CONDITION? YES ☐ NO ☐

ARE YOUR SYMPTOMS ☐CONSTANT OR ☐INTERMITTENT

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)

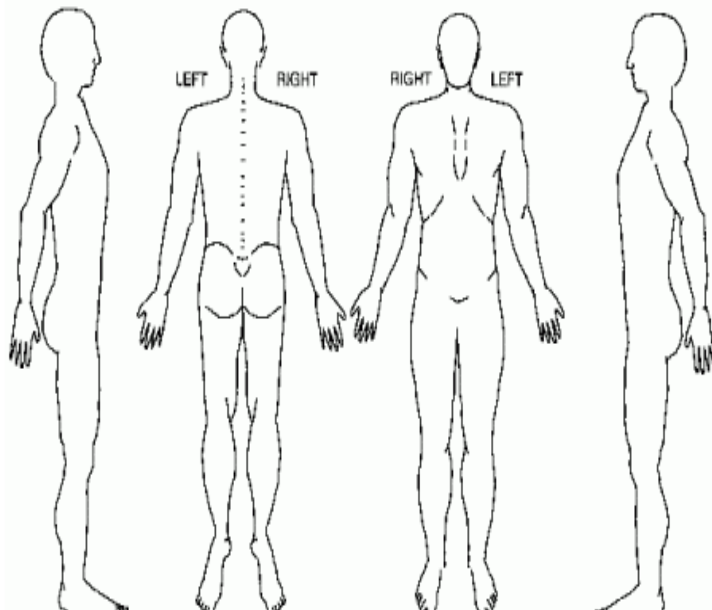
PREVIOUS MEDICAL INTERVENTION FOR THIS CONDITION (PLEASE CIRCLE): X-RAY/MRI/CATSCAN

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

____

____

DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS.



SEVERE PAIN *****

MODERATE PAIN 00000

DULL ACHE !!!!!!!!

RADIATING PAIN ↓↑↓

NUMBNESS/TINGLING XXXXX