Patient Acct#:_____

PHYSICAL THERAPY INITIAL EVALUATION FORM

PATIENT INFORMATION **Date:**_____

Name:_____ Occupation:_____
(Last) (First)

Birthdate:_____ Age:_____ Height:_____ Weight:_____lbs

Home/Cell Phone:_____ Employer:_____

Currently Employed? ○ YES ○ NO ○ MODIFIED

REHAB INFORMATION

1. Chief complaint/Ailment/Injury:_____
2. Date of Injury:_____ Date of Surgery:_____ ○ **WC** ○ **MVA**
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: ○ Worse ○ Same ○ Better
6. Are your symptoms: ○ Constant **OR** ○ Intermittent
7. Mark the number that best corresponds to your pain:

At Best:	1	2	3	4	5	6	7	8	9	10 (Excruciating Pain)
At Worst:	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 Positions	☐ Lying	☐ Medication	☐ 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 Positions	☐ Lying	☐ Worse in AM	☐ Worse in PM
☐ Worse as day progresses	☐ N/A cast just removed		

10. Previous medical intervention (Mark all that apply)

☐ X-ray/MRI ☐ CATSCAN ☐ Injections Other _____

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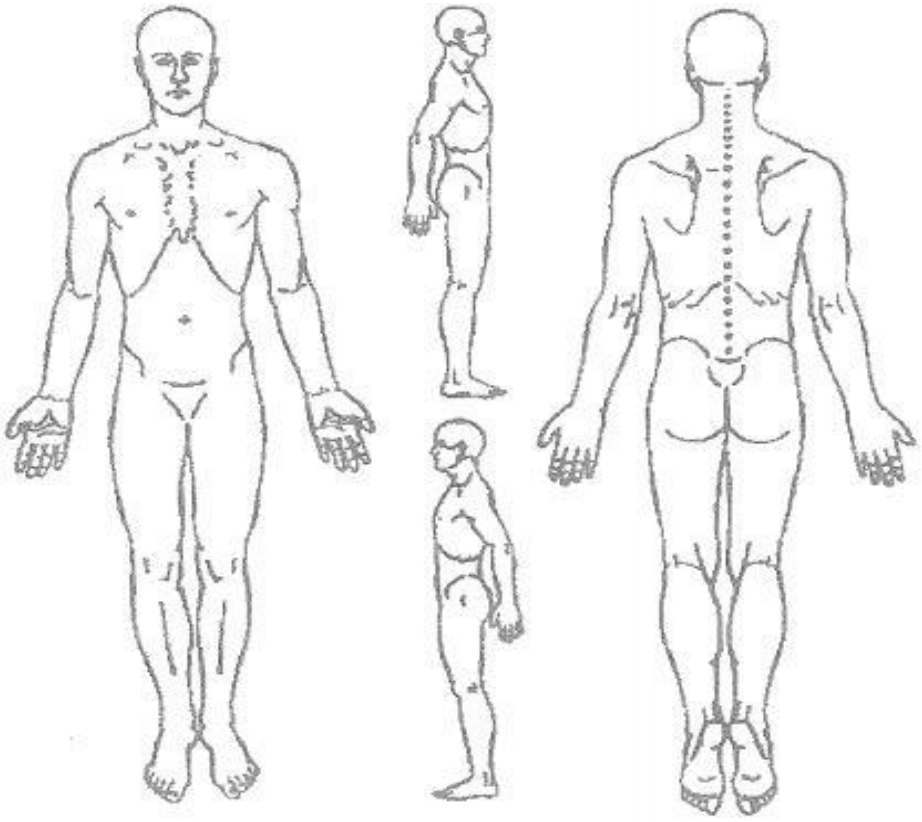
11. What are your goals to be achieved by the end of therapy?_____

_____

_____

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	0000000
DULL ACHE	∩∩∩∩∩∩∩
RADIATING PAIN	↑↓↑↓↑↓↑↓
NUMBNESS/TINGLING	XXXXXX

MEDICAL INFORMATION (Mark all that apply) This information is confidential and remains part of your chart.**

- ☐ Difficulty Swallowing
- ☐ Arthritis
- ☐ High Blood Pressure
- ☐ Heart Trouble
- ☐ Pacemaker
- ☐ Epilepsy/Seizures
- ☐ History of Drug Abuse
- ☐ Myofascial Pain
- ☐ Cancer
- ☐ Motion Sickness
- ☐ Fever/Chills/Sweats
- ☐ Unexplained Weight Loss
- ☐ Blood Clots
- ☐ Shortness of Breath
- ☐ History of Smoking
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Stroke
- ☐ Osteoporosis
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ HIV/Hepatitis
- ☐ History of Alcohol Abuse
- ☐ Depression/Anxiety
- ☐ Pregnancy

Previous Surgeries: _____

Other: _____

Medications: _____

_____

_____

Allergies: _____