Patient#_____ Provider_____

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_____

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: ○ 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 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 POSITIONING	☐ 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_____

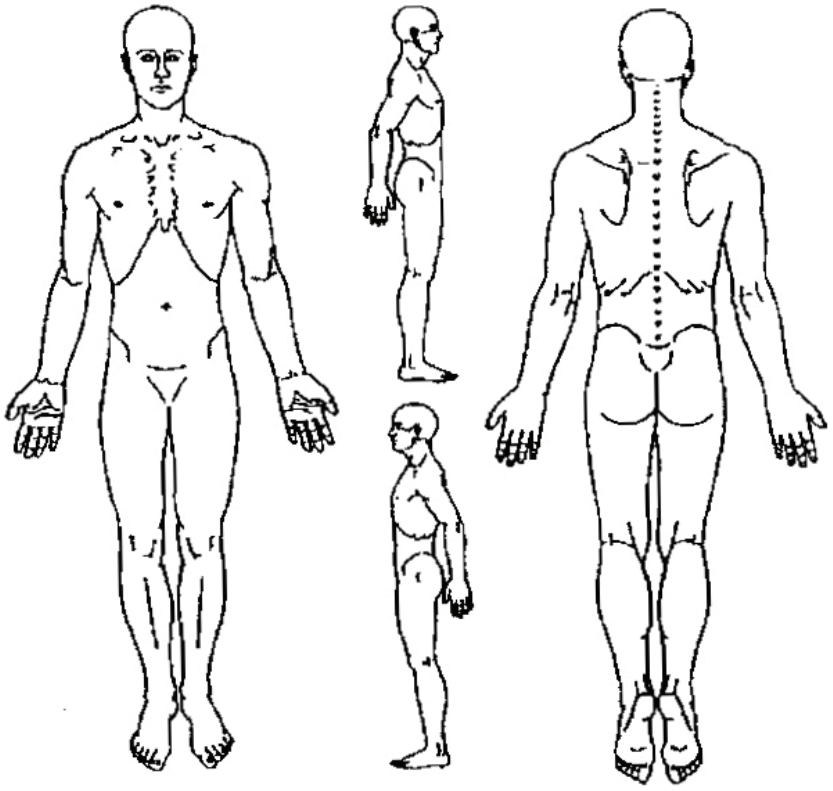
Patient#_____ Provider_____

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	00000000
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	☐ MOTION SICKNESS	☐ STROKE
☐ ARTHRITIS	☐ FEVER/CHILLS/SWEATS	☐ OSTEOPOROSIS
☐ HIGH BLOOD PRESSURE	☐ UNEXPLAINED WEIGHT LOSS	☐ ANEMIA
☐ HEART TROUBLE	☐ BLOOD CLOTS	☐ BLEEDING PROBLEMS
☐ PACEMAKER	☐ 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:_____

MEDICATIONS:

_____

_____

ALLERGIES:_____