

BodyWise Therapy

Initial Evaluation Subjective Report

Name:	_Date:	
How do you prefer to be addressed?		_Age:
Occupation:	_Height:	_Weight:
Address:		
Phone/Fax: E-Mail Address:		
How did you hear about BodyWise Therapy?		
Referring Physician:		
Address:		
Phone/Fax:		
Family Physician:		
Address:		
Phone/Fax:		
The following is very important to our evaluation process. as possible to provide us with a clear picture of your present. What is the primary complaint that brings you here to BodyWi specifically as possible.	nt symptoms, abilities	, and goals.
2. Secondary complaint?		
3. On what date did your symptoms begin?		

4. How did your symptoms begin? For example, did your symptoms begin as a result of an accident or trauma, or did

they begin without a known reason?

5. Have you ever length of treatmen				atment f	or this c	ondition ⁶	? If yes,	please in	dicate the	e type of treatment,
Physical Therapy:										
Other Treatment S	ervices (C	hiroprac	tor/Mass	ages):						
6. Put a slash mark	on the lin	ie below	to indica	te the IN	ITENSI	ГҮ of you	ur sympt	oms:		
None 0_	1	2	3	4	5	6	7	8	9	10 Worst Possible
7. Put 2 slash mark	ks on the li	ne below	v to indic	ate the E	BEST and	d WORS	T your s	ymptoms	have be	en in the past week:
None0	1	2	3	4	5	6	7	8	9	Worst Possible
Never 9. What activities	s or positio								(Constant
10. What activition	es or posit	ions dec	rease yo	ur pain?	•					
11. On the lines be	elow, place	e a slash	mark to i	ndicate y	our daily	y function	nal abilit	y as a pei	centage (of normal:
On a "go	od day" 09	%							10	0%
On a "ba	d day" 0%	%							10	00%

12. For each activity listed below, please note the amount of time in minutes or hours that you can perform before you feel that you need to stop because of your symptoms. If you have no difficulty with the activity, mark OK; if you are unable to perform the activity, mark UNABLE; if this does not apply to you, mark NA.

Activity	Tolerance	Activity	Tolerance
Sitting		Computer work	
Standing		Exercise	
Walking		Writing	
Stairs (# of stairs/flights)		Shopping	
Driving		Bending	
Sleeping		Reaching (# of repetitions)	
Lifting (# of pounds)		Carrying (# of pounds)	
Other		Other	
Other		Other	

13. What are your goals for this treatment program? For example, what activities from the above list would you like to be able to perform better or longer? How long in minutes or hours do you need or want to perform each activity for your work or recreation?

14. Do you have any of the following medical conditions?

	Yes	No		Yes	No
Circulatory problems			Blackouts		
High blood pressure			Visual disturbances		
Heart trouble			Recent or rapid weight changes		
Pacemaker			Headaches		
Epilepsy			Ringing in the ears		
Diabetes			Bowel/bladder problems		
Pregnancy			Malignancy		
Stroke			Other		

15. Allergies: Please list any allergies to medications and/or latex.

16. Past Medical History: Please list any surgeries, traumas, accidents or other conditions and the dates of occurrence.

Headache	Feeling	inadequate/unable to cope			
Heart pounding or racing	Feeling				
Irregular heartbeat		Uncontrolled crying or sadnessEasily annoyed or irritatedFree-floating anxiety about lifeVoice quivering, shakingEyes irritated of inflamed			
Chest pain, tightness					
Numbness, tingling in arm or leg					
Can't keep warm enough	_				
Sweaty palms	•				
Blushing, flushing face		Vision blurredEyestrain or discomfort			
Coughing					
Stuffy nose, congestion	Noseble				
Earache or ringing noise in ears	Stomacl	=			
Common colds		rn or indigestion			
Sore throat	Nausea				
Asthma or shortness of breath	Frequen	t urination			
Hay fever or allergies	Incompl	ete urination			
Sore, aching muscles	Painful				
Stiff or tender joints		Urinary leakage Bowel leakage Gas in lower bowel Diarrhea Constipation Bowel irregularity Uninterested in sexual relations Unable to participate in sex acts			
Back problems					
Trembling/twitching muscles					
Skin rashes, eruptions					
Grinding of teeth (TMJ)					
Dry mouth	Bowel is				
Mouth sores	Unintere				
Excessive perspiration					
Difficulty sleeping through the night		Menstrual difficultiesBreast tendernessHot flashesWater retentionOver-eating, bingeing			
Excessive drowsiness during the day					
Periods of extreme fatigue					
Feeling faint or dizzy					
Feeling tense or nervous		Lack of appetite			
Difficulties with family or friends Worrisome thoughts	Excessive	Excessive alcohol abuse			
	Other su	Other substance abuse			
Recurring bad thoughts	Frequen	Frequent laxative use			
Thoughts of suicide	Other:	Other:			
Fearful of persons or places					
MEDICATIONS: Please indicate below ALL which you are using them, the dosages, and	_	currently taking, the problem f			
		Effectiveness			
ication For Treatment of	Dose / Amt / Day	Effectiveness			
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