



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. Please fill out these forms as specifically as possible to provide us with a clear picture of your present symptoms, abilities, and goals.

1. What is the primary complaint that brings you here to BodyWise Therapy? Please describe your symptoms as specifically as possible.

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 received the following treatment for this condition? If yes, please indicate the type of treatment, length of treatment and effectiveness.

Physical Therapy: _____

Other Treatment Services (Chiropractor/Massages): _____

6. Put a slash mark on the line below to indicate the **INTENSITY** of your symptoms:

None 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 Worst Possible

7. Put 2 slash marks on the line below to indicate the **BEST** and **WORST** your symptoms have been in the past week:

None 0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ Worst Possible

8. Put a slash mark on the line below to indicate the **FREQUENCY** of your symptoms:

Never _____ Constant

9. What activities or positions increase your pain?

10. What activities or positions decrease your pain?

11. On the lines below, place a slash mark to indicate your daily functional ability as a percentage of normal:

On a "good day" 0% _____ 100%

On a "bad day" 0% _____ 100%

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			Ringling 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.

19. Please shade area(s) of pain and/or symptoms.

