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Initial Evaluation Subjective Intake

The following is a very important part of the evaluation process. Please fill out this form as specifically as possible to provide your therapist with a clear picture of your present functional status and symptoms.

Date _____

Name _____ e-mail _____

Phone number: Home _____ Cell _____ Work _____

Address _____

Age _____ Date of Birth _____ Occupation _____

Primary Physician _____ Physician's phone number _____

How did you hear about Shala Therapy? _____

Who can we thank for referring you to Shala Therapy? _____

What is the primary complaint that brings you to Shala Therapy today? _____

_____

Secondary complaint? _____

As a result, I am now having difficulty with _____

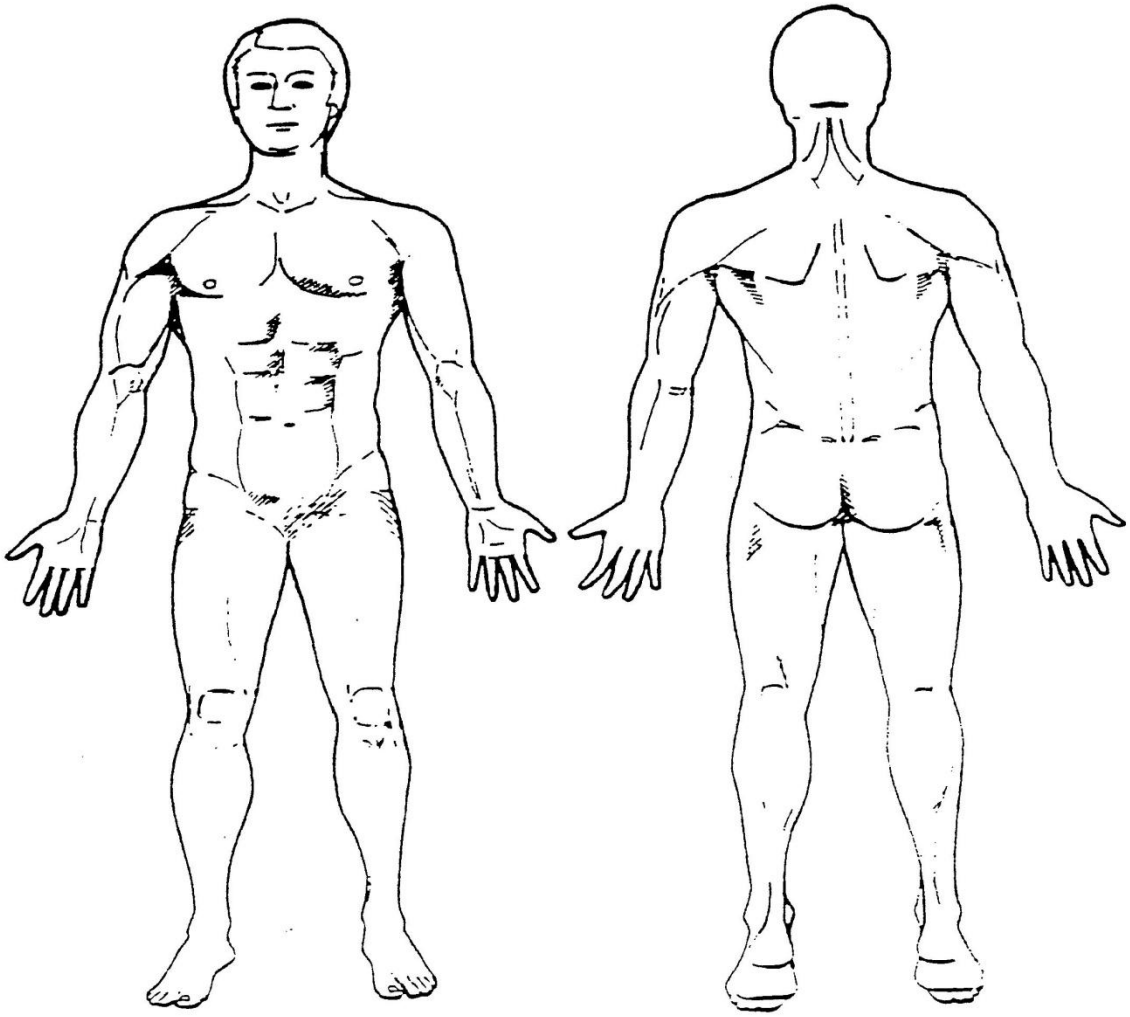
_____

Are you currently experiencing pain as a result of these symptoms? _____

If yes, can you describe your pain? _____

Please rate your pain on a scale from 0 – 10 (where 0 is no pain and 10 is the most excruciating pain imaginable) _____

Please shade in areas of pain in the diagram below:



When did your symptoms begin? _____

How did your symptoms begin? _____

_____

Have you received any of the following treatment(s) for this condition?

	Yes/No	How Long?	Was it helpful?
Physical Therapy	_____	_____	_____
Chiropractic Care	_____	_____	_____
Acupuncture	_____	_____	_____
Myofascial Release	_____	_____	_____
Other	_____	_____	_____

Please check if you have had any of the following medical conditions?

_____ circulatory problems

_____ high blood pressure

_____ heart trouble

_____ pacemaker

_____ epilepsy/seizures

_____ diabetes

_____ pregnancy

_____ stroke

_____ bowel/bladder problems

_____ blackouts

_____ visual problems

_____ headaches/migraines

_____ ringing in the ears

_____ malignancy

_____ weight change

_____ arthritis (rheumatoid/osteo)

_____ metal implants

_____ other _____

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

_____

_____

_____

Please list ALL medications you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal, and homeopathics.)

Medication	For Treatment of	Dose/Amount per day	Effectiveness

Are you currently pregnant or is there a possibility you maybe pregnant?_____

Do you currently exercise and/or participate in any sports? _____

What type and how often? _____

Are you able to exercise now? _____

Do you experience any discomfort, shortness of breath, or pain with these activities? _____

Please list all the tasks/activities that you have difficulty performing and your tolerance to those activities.

Task/Activity	Tolerance (minutes/hours)

What are your goals for therapy? 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? _____

_____

_____

_____

_____

Thank you for taking the time to fill out this evaluation form. All your personal health information is confidential.