INITIAL EVALUATION FORM

Name____ Date ____________

Present Condition

Date of Accident ____________ Injury _________ or Last Flare-up ________________

When did your symptoms first appear?_______________

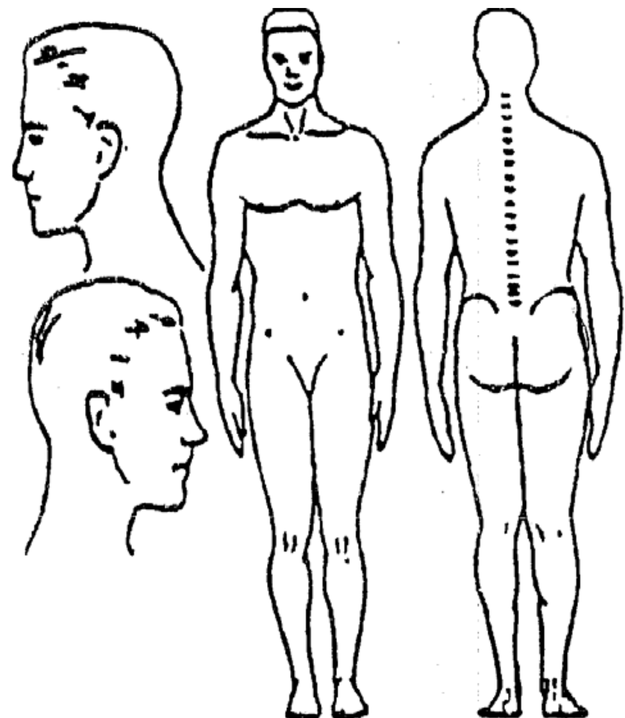
Describe incident ____
____
____

What activity were you doing when injured**? (Circle or Check)**

Driving Bending/Lifting How much Weight?_________
Sitting Other Activity____________________________

Did you feel pain immediately YES / NO Were you in shock? YES / NO
Since your initial onset of symptoms has it gotten Worse Better Same
Did you use Ice? Y / N Heat? Y / N Take Medication Y / N Type_______________
If so, what has helped?________________

Mark Area on Body with Initial



Pain Description (circle and mark on body)

Burning	B	Stiff	S
Deep Dull Ache	D	Tight	T
Sharp Shooting	SS	Achy	A
Numbness	N	Throbbing	T
Weakness	W		

Pain Scale

One week after injury

1 5 10
I__________________I__________________I
mild moderate severe

Currently

1 5 10
I__________________I__________________I
mild moderate severe

What makes your symptoms worse and how long before pain begins?
(Please Check)

	Activity	How Long?
Sitting	______	______
Standing	______	______
Walking	______	______
Bending	______	______
Driving	______	______
Activities	______	______

What eases your pain?
Positions:

Back lying _____ Movement _____

Side lying _____ Stretching _____

Other ______________________________

<u>PAST MEDICAL HISTORY</u> - List **ALL** you can remember

	Year	Area Injured
Previous Accidents, Falls Or Injuries	_____	___________________________________
	_____	___________________________________
	_____	___________________________________
	_____	___________________________________

Did your current pain begin after any of the above listed accidents? _____________________

Do you have any other diagnosed problems? ____

Activity Levels:
Current activities/exercise you partake in outside of normal daily activities

Activity	How many times per week for how long?
______________________	____
______________________	____

Previous activities that you would like to resume _____________________________________

Do you sit at a desk most of the day? Y / N

Do you belong to a health club or gym? ____

Does the pain keep you from working out? ___________________

Are there any activities at work that increase you pain or discomfort? Phone Computer

Do you constantly have to shift positions to find comfort at work sitting or driving? Y / N

Stress Levels: Current Mild Mod Extreme

Any recent major life events (ie. divorce, death, etc)______________________________________
____

Please Check or Circle if you have ever had

Diabetes	High Blood Pressure	Heart Condition
Cancer	Arthritis	Neurological Disorder (MS/ ALS)
Fractures	Head Injury	Headaches
Dizziness	Difficulty walking	Bowel or Bladder changes
Night pain	Ulcers/ Stomach ailments	Circulation/Vascular problems
Loss of Balance	Infectious Disease	Shortness of breath
Vision loss	Hearing Loss	Chest pain
Difficulty sleeping		

Medications currently taking: For what condition

__________________________ ____________________________
__________________________ ____________________________

Steroids History Type of Steroid Date
Injection or ______________________ ___________
Inhalant ______________________ ___________

Surgery History Surgery Date

_______________________ ___________
________________________ ___________

Have you received any previous Physical Therapy, Chiropractic or other Body Work?

When? ___________ How Long?_________ Did you fully recover?______________

What goals do you want to achieve through Physical Therapy?
____
____
____