

**PHYSICAL THERAPY INITIAL EVALUATION FORM****PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_  
(LAST) (FIRST) OCCUPATION \_\_\_\_\_

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 ☐ BETTER6. 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)

- |   |                                   |                                     |   |
|---|-----------------------------------|-------------------------------------|---|
| <input type="checkbox"/> BENDING            | <input type="checkbox"/> MOVEMENT | <input type="checkbox"/> REST       | <input type="checkbox"/> BETTER IN AM             |
| <input type="checkbox"/> SITTING            | <input type="checkbox"/> STANDING | <input type="checkbox"/> HEAT       | <input type="checkbox"/> BETTER AS DAY PROGRESSES |
| <input type="checkbox"/> RISING             | <input type="checkbox"/> WALKING  | <input type="checkbox"/> ICE        | <input type="checkbox"/> BETTER IN PM             |
| <input type="checkbox"/> CHANGING POSITIONS | <input type="checkbox"/> LYING    | <input type="checkbox"/> MEDICATION | <input type="checkbox"/> N/A CAST JUST REMOVED    |

9. WHAT INCREASES/MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

- |  |  |                                      |                                      |
|--|--|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> BENDING                 | <input type="checkbox"/> MOVEMENT              | <input type="checkbox"/> REST        | <input type="checkbox"/> SNEEZE      |
| <input type="checkbox"/> SITTING                 | <input type="checkbox"/> STANDING              | <input type="checkbox"/> STAIRS      | <input type="checkbox"/> DEEP BREATH |
| <input type="checkbox"/> RISING                  | <input type="checkbox"/> WALKING               | <input type="checkbox"/> COUGH       | <input type="checkbox"/> MEDICATION  |
| <input type="checkbox"/> PROLONGED POSITIONING   | <input type="checkbox"/> LYING                 | <input type="checkbox"/> WORSE IN AM | <input type="checkbox"/> WORSE IN PM |
| <input type="checkbox"/> WORSE AS DAY PROGRESSES | <input type="checkbox"/> N/A CAST JUST REMOVED |                                      |                                      |

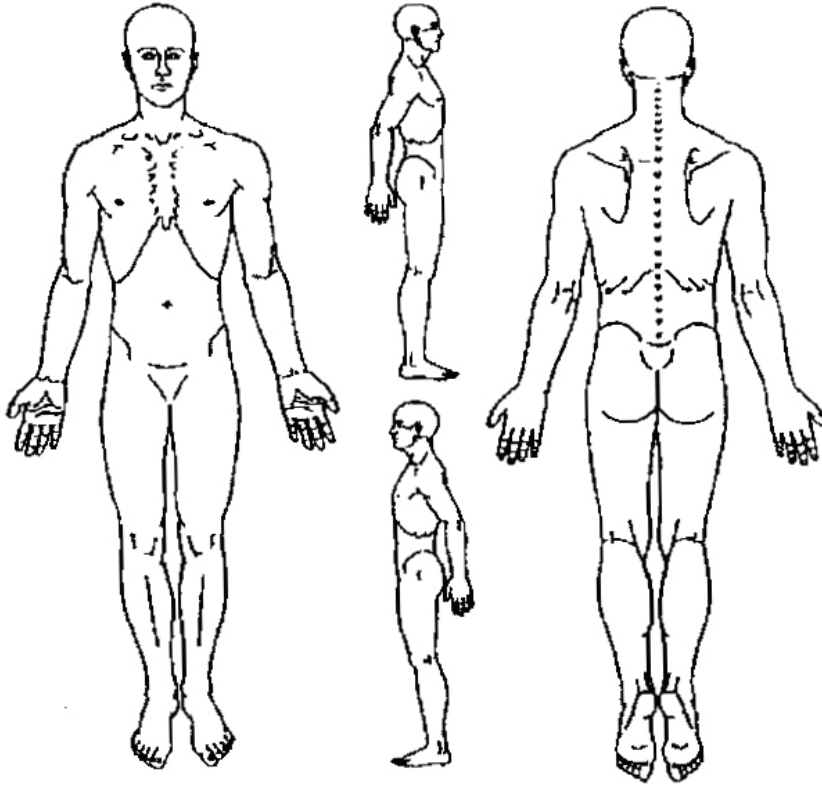
10. PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

☐ X-RAY ☐ MRI ☐ CATSCAN ☐ INJECTIONS OTHER \_\_\_\_\_

11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY?

Patient# \_\_\_\_\_ Provider \_\_\_\_\_

**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	nnnnnnnn
RADIATING PAIN	↑↓↑↓↑↓↑↓
NUMBNESS/TINGLING	XXXXXXX

**MEDICAL INFORMATION (MARK ALL THAT APPLY) \*\*THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> DIFFICULTY SWALLOWING | <input type="checkbox"/> MOTION SICKNESS         | <input type="checkbox"/> STROKE                   |
| <input type="checkbox"/> ARTHRITIS             | <input type="checkbox"/> FEVER/CHILLS/SWEATS     | <input type="checkbox"/> OSTEOPOROSIS             |
| <input type="checkbox"/> HIGH BLOOD PRESSURE   | <input type="checkbox"/> UNEXPLAINED WEIGHT LOSS | <input type="checkbox"/> ANEMIA                   |
| <input type="checkbox"/> HEART TROUBLE         | <input type="checkbox"/> BLOOD CLOTS             | <input type="checkbox"/> BLEEDING PROBLEMS        |
| <input type="checkbox"/> PACEMAKER             | <input type="checkbox"/> SHORTNESS OF BREATH     | <input type="checkbox"/> HIV/HEPATITIS            |
| <input type="checkbox"/> EPILEPSY/SEIZURES     | <input type="checkbox"/> HISTORY OF SMOKING      | <input type="checkbox"/> HISTORY OF ALCOHOL ABUSE |
| <input type="checkbox"/> HISTORY OF DRUG ABUSE | <input type="checkbox"/> DIABETES                | <input type="checkbox"/> DEPRESSION/ANXIETY       |
| <input type="checkbox"/> MYOFASCIAL PAIN       | <input type="checkbox"/> FIBROMYALGIA            | <input type="checkbox"/> PREGNANCY                |
| <input type="checkbox"/> CANCER                |  |   |

PREVIOUS SURGERIES: \_\_\_\_\_

OTHER: \_\_\_\_\_

MEDICATIONS: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_