



Initial Self-Evaluation

Please take a moment to fill out the following questions as accurately and truthfully as you are able. This information will greatly improve our ability to understand your problems. If you need any assistance with any part, please contact the front desk upon checking in for your appointment.

Date ___ / ___ / _____ Name _____ D.O.B ___ / ___ / _____

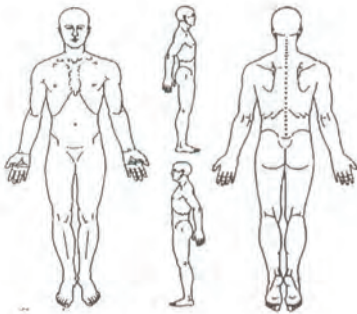
Sex M / F Occupation _____

Job Demands _____

Currently Working? YES / NO Part / Full Time If not working, what is anticipated date to return to work? ___ / ___ / _____

Restrictions? Yes / No (If yes, please describe.) _____

Tell me about your symptoms. Please use the diagram to tell me about the location of your symptoms. Check the appropriate words below that describe your symptoms.



- Sharp
- Stabbing
- Weakness
- Unstable
- Radiating
- Numb/Tingle
- Stiffness
- Dizziness
- Ache
- Burning
- Dull
- Other

Additional notes _____

Rate the severity of your symptoms on a scale of 0 to 10. (0 = no symptoms, 10 = severe requiring visit to ER)

Current ___ / 10; Worst ___ / 10; Best ___ / 10

Date of Injury/Onset ___ / ___ / _____ Date of Surgery ___ / ___ / _____

Describe what caused your pain/symptoms/injury _____

My symptoms are getting ___ Better ___ Worse ___ Same

I hurt when I do _____

I feel better when I do _____

Medical History. Have you had or do you now have any of the following?

- Diabetes / Neuropathy**
- High Blood Pressure**
- Heart Condition**
- Smoker ppd** _____
- Infectious disease**
- HIV Positive**
- Seizures**
- Stroke**
- Cancer**
- Asthma**
- Alcoholism**
- Depression**
- Anxiety**
- Fibromyalgia**
- Neurological condition**
- Osteoporosis / Osteopenia**
- Migraines**
- Dizziness**
- High Blood Pressure**
- Frequent falls**
- Bowel / Bladder abnormalities**
- Surgeries / Other** _____

Recent Diagnostic Studies

- X-Ray**
- MRI**
- Bone Scan**
- CT Scan**

Results _____

Previous treatments for this condition

- Injections**
- Medications**
- Physical Therapy**
- Home Health**
- Other body work** _____

Previous treatments made me:

Better **Worse** **Same**

Advanced Directive on file? Yes _____ No _____

Currently medications/supplements _____

What are your rehabilitation goals? _____

Describe your normal recreational activities? _____

Are you able to perform these activities now? YES / NO

How did you hear about us? Doctor Internet Insurance Company Personal Referral _____

Thank you for taking the time to tell me about your symptoms. I look forward to discussing them further with you.

Patient Signature

Date

Therapist Signature

Date