Patient Name: ______________________________ **Date of Birth:** ____________ **Date of Eval:** ___________

SUBJECTIVE

Age: _______ **When did your symptoms start?** ______________________________

Hand Dominance: ☐ Right ☐ Left **Date of next Doctor's appointment:** ____________________

Describe the current problem that brought you here: ______________________________

____

Are your symptoms: ☐ Improving ☐ Getting Worse ☐ Staying the Same

Have you had any testing? ☐ X-rays ☐ MRI ☐ EMG/ Nerve Conduction Test ☐ CT Scan

☐ Other **Results:** ______________________________

Have you ever had these symptoms before? ☐ Yes ☐ No **Description:** ____________________

Have you ever had treatment before for these symptoms? ☐ Yes ☐ No **If Yes, please describe:**

☐ **Medication:** **Beneficial?** ☐ Yes ☐ No **Explain:** ______________________________

☐ **Injection:** **Beneficial?** ☐ Yes ☐ No **Explain:** ______________________________

☐ **Physical Therapy:** **Beneficial?** ☐ Yes ☐ No **Explain:** ______________________________

☐ **Massage/Chiropractic:** **Beneficial?** ☐ Yes ☐ No **Explain:** ______________________________

Did you have surgery? ☐ Yes ☐ No **Date of Surgery:** ______________________________

If yes, what procedure did you have done? ______________________________

Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?

☐ Yes ☐ No **Explain:** ______________________________

THERAPIST COMMENTS:

____

CURRENT COMPLAINTS

If you have pain, what is your pain level?

(0 = No Pain, 10 = Extreme Pain – Circle)

AT WORST:	0	1	2	3	4	5	6	7	8	9	10
AT BEST:	0	1	2	3	4	5	6	7	8	9	10
CURRENTLY:	0	1	2	3	4	5	6	7	8	9	10

Mark the location of your pain with an "X":

FRONT BACK

Are your symptoms: ☐ Constant ☐ Come and Go ☐ Ache ☐ Deep ☐ Superficial ☐ Dull

☐ Sharp ☐ Shooting ☐ Burning ☐ Numbness/Tingling

☐ Other: ______________________________

Day Pattern:

Does your pain seem to be WORSE at a certain time of day? ☐ Yes ☐ No

If Yes, ☐ Morning ☐ Night ☐ Other: ______________________________

Does your pain progress as the day goes along? ☐ Yes ☐ No

If Yes, please explain: ______________________________

Do you have difficulty falling asleep? ☐ Yes ☐ No **If Yes, please explain:** ____________________

Do you wake due to pain? ☐ Yes ☐ No **If Yes, # of times per night:** ____________________

THERAPIST COMMENTS:

____

FUNCTIONAL ABILITIES AND RESTRICTIONS

What were you doing prior to this injury that you are unable to do currently? Please list any additional activities that you are having difficulty completing. ______________________________

☐ Squatting ☐ Sitting ☐ Driving ☐ Reaching ☐ Work Tasks ☐ Gripping/Pinching
☐ Standing ☐ Walking ☐ Lifting ☐ Dressing/Grooming ☐ Stairs ☐ Position Changes
☐ Kneeling ☐ Holding/Carrying Objects
☐ Other: ______________________________

What activities make your pain WORSE? ______________________________

What activities make your pain BETTER? ______________________________

What household duties are you having difficulty performing? ☐ Cooking ☐ Cleaning ☐ Vacuuming
☐ Laundry ☐ Yard Work ☐ Grocery Shopping ☐ Other: ____________________

Do you use an assistive device? ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: ____________________

Did you use an assistive device prior to current injury/conditions? ______________________________

Hobbies/ Interests/ Exercise: ______________________________

THERAPIST COMMENTS:

____

Patient Name: ____ **Date of Birth:** ____________ **Date of Eval:** ___________

WORK HISTORY/ SOCIAL HISTORY/ INTERESTS/ LIVING ENVIRONMENT

Occupation: ____ **Presently Working:** ☐ Yes ☐ No

If Yes, ☐ **Full Duty** ☐ **Limited Duty: Restrictions:** ____________________ **# Days Off Work:** _____

Job Duties: ☐ **Sitting** ☐ **Computer Work** ☐ **Bending** ☐ **Heavy Lifting** ☐ **Traveling** ☐ **Standing**
☐ **Reaching** ☐ **Crawling** ☐ **Twisting** ☐ **Walking** ☐ **Pushing/Pulling**
☐ **Gripping/Pinching** ☐ **Other:** ____

Are you now, or have you ever been disabled (service or work)? ☐ **Yes** ☐ **No** **If Yes, when?** __________
If Yes, please explain: ____

What is your current living arrangement? ☐ **Alone** ☐ **Spouse** ☐ **Partner** ☐ **Family** ☐ **Other:** __________

Does your home have stairs? ☐ **Yes** ☐ **No** **If Yes, # of stairs:** ______________________________

If Yes, do your stairs have handrail? ☐ **Yes** ☐ **No** **If Yes, which side going up?** ☐ **Right** ☐ **Left** ☐ **Both**

THERAPIST COMMENTS:
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PREVIOUS MEDICAL HISTORY/ MEDICAL PRECAUTIONS AND CONTRAINDICATIONS

How would you classify your general health? ☐ **Good** ☐ **Fair** ☐ **Poor**

In terms of your general health, please check ALL that apply:

☐ Allergies	☐ Anemia	☐ Liver/Gallbladder Problem
☐ Rheumatoid Arthritis	☐ **Recent Fever**	☐ Fibromyalgia
☐ Metal Implants	☐ **Ringing of the Ears**	☐ Asthma/Breathing Difficulties
☐ **Recent Headaches**	☐ **Recent Nausea/Vomiting**	☐ Seizures/Epilepsy
☐ **Recent Vision Changes**	☐ Heart Attack	☐ **Recent Dizziness/Fainting**
☐ Sexual Dysfunction	☐ **Cancer**	☐ **Recent Change in Bowel/Bladder Habits**
☐ Osteoarthritis	☐ Skin Abnormalities	☐ **Pain with Cough/Sneeze**
☐ Heart Palpitations	☐ Osteoporosis	☐ Smoking History
☐ Chest Pain/Angina	☐ Hernia	☐ Pacemaker
☐ Stroke/TIA	☐ Depression	☐ High/Low Blood Pressure
☐ Physical Abnormalities	☐ Surgeries	☐ Diabetes I or II
☐ Hypoglycemia	☐ Polio	☐ **Unexplained Weight Loss/Gain**
☐ **Night Pain**	☐ Intolerance to Cold/Heat	☐ Pregnancy (Currently)
☐ Urine Leakage	☐ Recent Fractures	☐ **Recent Unexplained Fatigue**
☐ Kidney Problems	☐ Heart Disease	☐ **Numbness/Tingling in Hip/Buttocks Area**

Is there any other information regarding your medical history or are there any factors that may complicate your ability to participate in therapy that we should know about? ______________________________
____
____

Have you had any falls in the past 12 months? ☐ **Yes** ☐ **No** **If Yes, how many times?** ____________
If Yes, please describe the nature of the fall (s): ____
If Yes, please describe if an injury(ies) occurred: ____
____

THERAPIST COMMENTS:
☐ **See Attached List**
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MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)*] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]:
____
____
____

THERAPIST COMMENTS:
☐ **See Attached List**
____
____
____

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy? (I.E: performing household tasks without pain)
____
____

THERAPIST COMMENTS:
____
____

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: ____ **Date:** _______________
Therapist's Signature: ____ **License #:** ____________ **Date:** _______________
Printed Therapist's Name: ____