

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

## PHYSICAL THERAPY INITIAL EVALUATION FORM

### PATIENT INFORMATION

DATE \_\_\_\_\_

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

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

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4. HAVE YOU RECEIVED THERAPY FOR THIS CONDITION? YES NO WHEN? \_\_\_\_\_

HOW MANY VISITS? \_\_\_\_\_

5. HAS YOUR CONDITION BEEN GETTING: WORSE SAME BETTER

6. 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)

BENDING	MOVEMENT	REST	BETTER IN AM
SITTING	STANDING	HEAT	BETTER AS DAY PROGRESSES
RISING	WALKING	ICE	BETTER IN PM
CHANGING POSITIONS	LYING	MEDICATION	N/A CAST JUST REMOVED

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

BENDING	MOVEMENT	REST	SNEEZE
SITTING	STANDING	STAIRS	DEEP BREATH
RISING	WALKING	COUGH	MEDICATION
PROLONGED POSITIONING	LYING	WORSE IN AM	WORSE IN PM
WORSE AS DAY PROGRESSES	N/A CAST JUST REMOVED		

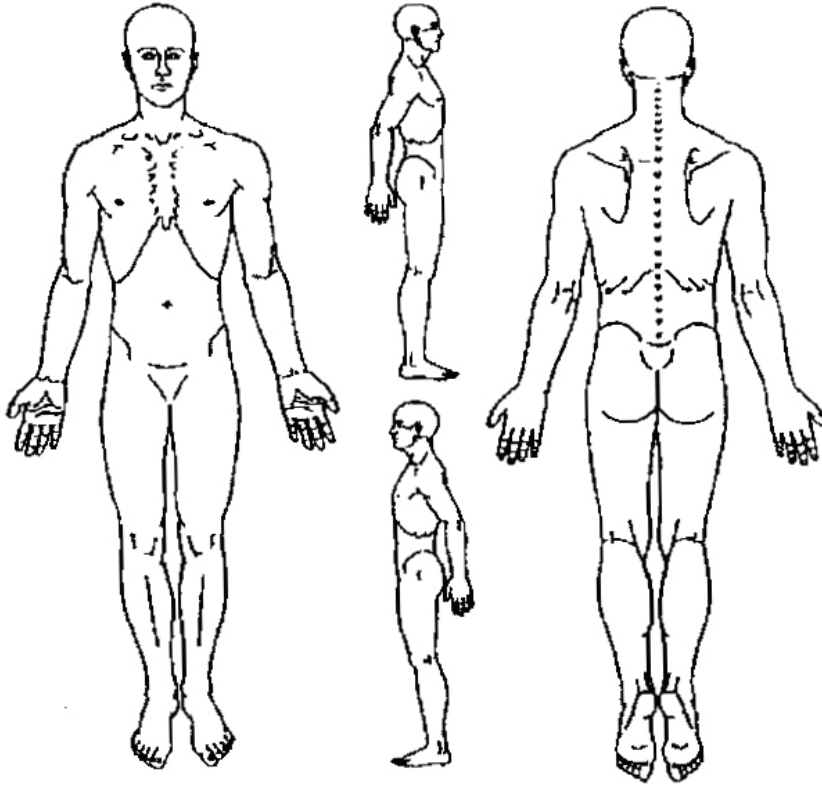
10. PREVIOUS MEDICAL INTERVENTION (MARK ALL THAT APPLY)

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

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

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**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**

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

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

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

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

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