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** _____

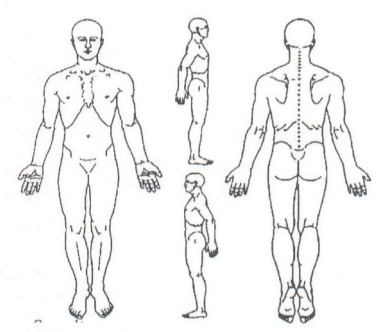
Job Demands _____

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 __ Radiating __ Ache
__ Stabbing __ Numb/Tingle __ Burning
__ Weakness __ Stiffness __ Dull
__ Unstable __ Dizziness __ 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