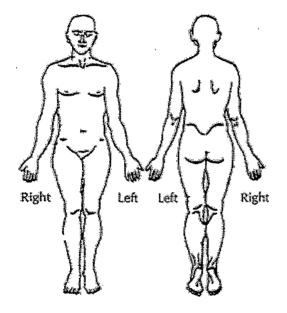


## **Initial Evaluation For Physical Therapy**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Do you CURRENTLY have pain as a result of this injury? YES NO

If yes, please mark the areas where you have pain on the body chart below.



If you have pain in more than one major area of the body, please list which area is your primary and/or secondary concern:

- 1.
- 2.
- 3. 4.

How would you describe your pain?

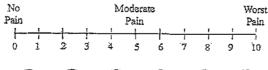
ACHE STIFFNESS SHARP BURNING PULSATING OTHER:

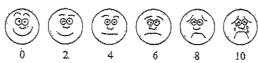
is your pain CONSTANT or INTERMITTENT?

Using the pain scale below please rate how your pain varies in a typical day:

Worst pain level (i.e. with activity or when NOT using pain medication):

Lowest pain level (i.e. at rest or when using pain medication): \_\_\_\_\_\_\_.





Do you have any numbness or tingling associated with this injury? YES NO Where? If yes, please describe: When?\_\_\_\_\_ How often?\_\_\_\_\_ Do you have any increased pain with any of the following? DEEP BREATHING COUGHING **SNEEZING** Have there been any changes in your BOWEL or BLADDER function associated with this injury? (For example: loss of control or inability to go): YES If yes, please describe: \_\_\_\_\_\_\_ What positions, movements or activities aggravate your pain? (i.e. What makes your pain worse?): What have you tried thus far that alleviates your pain, even if only temporarily? (i.e. What makes you feel better?): Are your symptoms typically worse in the MORNING, MID-DAY or EVENING? Is your sleep interrupted due to pain or discomfort from this injury? YES NO

YES

NO

Do you have any headaches associated with this injury?

Please provide details of any medical intervention, evaluation or treatment have you had thus far. For example: when, where, what type of treatment, was it effective? ER/Urgent Care: \_\_\_\_\_\_\_ Occupational Medicine Physician: \_\_\_\_\_\_ Specialist: \_\_\_\_\_\_ Physical Medicine: CHIROPRACTIC PHYSICAL THERAPY ACCUPUNCTURE MASSAGE OTHER: Have you had any diagnostic imaging for this injury? YES NO If yes, please provide details: Type of imaging: X-RAYS MRI CT SCAN OTHER: Date(s): \_\_\_\_\_\_ Results/Findings: \_\_\_\_\_\_ Since the onset of your injury, overall would you say your pain is: STAYING THE SAME GETTING WORSE **GETTING BETTER** Have you ever injured this area(s) before? YES NO If yes, please provide details: When: \_\_\_\_\_\_ Treatment Received: Did you fully recover? YES NO

If no, what symptoms remained? \_\_\_\_\_

Do you have any other health conditions, illnesses or injuries that could affect your treatments or exercise? YES NO
HIGH BLOOD PRESSURE DIABETES HEART DISEASE COPD ASTHMA ARTHRITIS PREVIOUS POSITIVE COVID DIAGNOSIS CSF PRESSURE ISSUES/CHIARI MALFORMATION KIDNEY DISEASE JOINT PROBLEMS PAIN/MOBILITY ISSUES (unrelated to this injury) PREGNANCY EDEMA VARICOSE VEINS THROMBOSIS OSTEOPOROSIS
OTHER:
Please list any prescription or non-prescription medications or supplements you are currently taking:
Do you have a latex allergy? YES NO
Please initial:
I understand that my success in Physical Therapy requires a collaborative effort between myself, my massage therapist and my doctor(s).
I understand Physical Therapy requires my full participation in treatments including
attending my appointments as scheduled, actively participating in any stretching and strengthening exercises recommended.
I understand that in addition to treatment in the clinic I also have a responsibility to learn how to care for myself/my injury at home for optimal outcome.
X
PRINT NAME
x
SIGN NAME DATE