Initial Evaluation For Physical Therapy

Oregon Occupational Medicine

Today's Date: ______________

Name: ______________________ DOB: _________

Date of Injury: ________________

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.

Right Left Left Right

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): ___________________

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

0 2 4 6 8 10

Do you have any headaches associated with this injury? YES NO

Do you have any numbness or tingling associated with this injury? YES NO

If yes, please describe: Where?______________________________

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 NO

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

Occupation: ______________________

Currently Working: YES NO

If yes: REGULAR DUTY MODIFIED DUTY

If on modified work duty, list your current work restrictions recommended by your primary doctor for this injury: ____

____

If you are NOT working, please provide the reason

DOCTORS ORDER MODIFIED DUTY NOT AVAILABLE WITH EMPLOYER

NO LONGER WORKING (i.e. quit, fired, laid off)

OTHER: ________________________

What are the physical requirements of your REGULAR work?

LIFTING/CARRYING: _____lbs (maximum weight lifted/carried by yourself)

PUSHING/PULLING: _____lbs (maximum weight push/pull by yourself)

Any additional physical requirements of your REGULAR job?

REACH CLIMB SQUAT STOOP/BEND TWIST

STAIRS/STEPS KNEEL CRAWL BALANCE

OTHER: ____

Since the onset of your injury, overall would you say your pain is:

GETTING WORSE STAYING THE SAME GETTING BETTER

Please describe how your injury occured: ______________________________________

____

____

____

When did your pain start? IMMEDIATELY

LATER (Same day, next day, other): ____

GRADUALLY OVER TIME (How long?): ____

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: ______________________________

Primary Care Physician: ______________________________

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:

GETTING WORSE STAYING THE SAME 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