OCCUPATIONAL MEDICINE

Service, Gratitude, & Integrity

Initial Evaluation For Physical Therapy

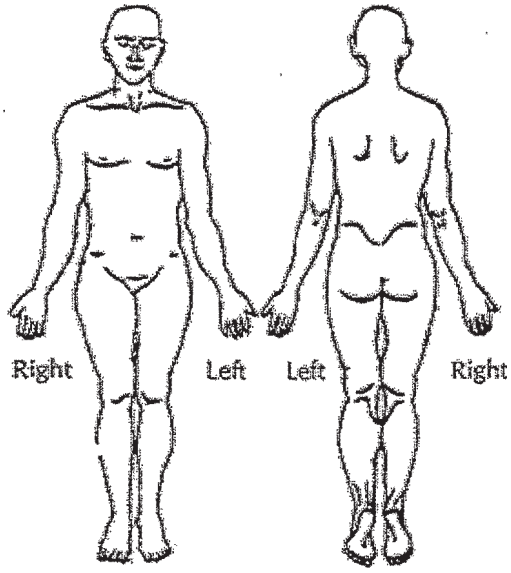
Today's Date: _____

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.



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?

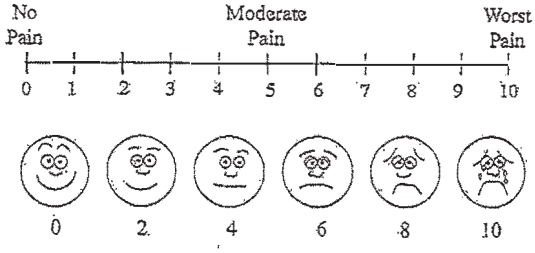
☐ACHE ☐STIFFNESS ☐SHARP ☐BURNING ☐PULSATING ☐OTHER: _____

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 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: _____

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