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**_____ **Age**_____ **Sex** M / F
Marital Status S M D W **Race**_____ **Education** HS / College / Grad
Occupation_____ **Currently Working?** Yes / No
Work Demands _____
Current Work Restrictions_____

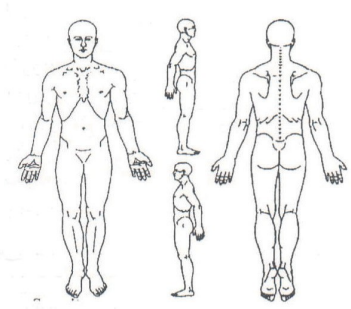
History of Current Injury

Date of Injury or Estimated Onset _____/_____/_____
Date of Surgery _____/_____/_____

Cause of injury/symptoms_____

_____

Tell me about about your symptoms



Please use the diagram to indicate the location of your symptoms and check the appropriate words below that best describe your symptoms

___ Dull Ache	___Sharp/Stabbing	___Stiffness
___Burning	___Numbness/Tingling	___Radiating
___Throbbing	___Constant	___Intermittent
___Weakness	___Swelling	___Bruising

Other:_____

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

Are your symptoms getting ____Better ____Worse ____Same

Do your symptoms ease when you rest in a comfortable position? ___Yes ___No

Do your symptoms disrupt your sleeping? ___Yes ___No

Have you recently had a fever, infection, or other illness? ___Yes ___No

Aggravating factors_____

Easing factors_____

Previous treatments for this condition

- ❑ Injections
- ❑ Medications
- ❑ Physical Therapy
- ❑ Home Health
- ❑ Other body work _____

Previous treatments made me:

___Better ___Worse ___Same

Medical History *Please check below if you have been diagnosed with or received medical treatment for any of the following conditions?*

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Heart Condition
- ❑ Heart Attack
- ❑ Pacemaker
- ❑ Stroke or TIA
- ❑ Cancer_____
- ❑ Seizure or Epilepsy
- ❑ Rheumatoid Arthritis
- ❑ Other Arthritic Conditions_____
- ❑ Osteoporosis or Osteopenia
- ❑ Neurological Condition_____
- ❑ Severe Headache or Migraine
- ❑ Dizziness or Frequent Falls
- ❑ Thyroid Condition
- ❑ Kidney Disease
- ❑ Bowel or Bladder Disorder
- ❑ Circulatory Problems or DVT
- ❑ Peripheral Neuropathy
- ❑ Anemia
- ❑ Asthma
- ❑ Pulmonary Condition
- ❑ Smoking ____ packs per day
- ❑ Alcohol or Chemical Dependency
- ❑ Depression
- ❑ Anxiety
- ❑ Fibromyalgia
- ❑ Prior Fractures_____
- ❑ Latex Sensitive
- ❑ Hearing Loss
- ❑ Vision Problems
- ❑ Sleep Disorder_____

Recent Diagnostic Studies

- ❑ X-Ray
- ❑ MRI
- ❑ Bone Scan
- ❑ CT Scan
- ❑ EMG

Results _____

_____

_____

Prior Surgeries *Please list with approximate date*

_____

_____

_____

_____

Recent Hospitalizations *Please describe with approximate date*

_____

_____

_____

_____

Family History *Has anyone in your immediate family ever been diagnosed with the following?*

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Heart Condition
- ❑ Stroke
- ❑ Cancer
- ❑ Arthritic Condition
- ❑ Anemia
- ❑ Kidney Disease
- ❑ Mental Illness
- ❑ Alcohol or Chemical Dependency

When was your last general physical exam? ___/___/_____ **Physician:**_____

Do you ever feel unsafe in your home or threatened by a family member? ___Yes ___No

Are you now or could you possibly be Pregnant? ___Yes ___No # of weeks:_____

Any recent changes in sleep quality, energy level, or appetite? ___Yes ___No

Have you recently been feeling down or uninterested in things you enjoy? ___Yes ___No

Regular Caffeine Intake? ___beverages per day **Alcohol Intake?** ___drinks per week

Do you regularly exercise? ___Yes ___No **# of days/week:** ____

Please mark any of the following that are New or Unusual for you:

- ❑ Unexplained weight loss/gain
- ❑ Night sweats
- ❑ Difficulty breathing
- ❑ Regular cough
- ❑ Heartburn / indigestion
- ❑ Heart racing/palpitations
- ❑ Excessive bleading or easy bruising
- ❑ Skin rash
- ❑ Constipation / diarrhea
- ❑ Blood in stools or urine
- ❑ Problems urinating or incontinence
- ❑ Arm or leg swelling

Are you currently taking any of the following Over The Counter medications?

- ❑ Aspirin
- ❑ Advil, Motrin, or Ibuprofen
- ❑ Aleve
- ❑ Decongestants or Antihistamines
- ❑ Tylenol
- ❑ Antacid
- ❑ Laxatives
- ❑ Supplements /Vitamins_____
- ❑ Herbal Medicines _____
- ❑ Other _____

Please list your current Prescription medications_____
_____

Describe your normal recreational activities_____
_____

What are your rehabilitation goals?_____
_____

How did you hear about us? **__Physician __Internet __Insurance Co __Personal Referral**_____

Thank you for taking the time to tell me about your symptoms and medical history.
I look forward to discussing them further with you.

_____ _____

Patient/Guardian Signature Date Therapist Signature Date