Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

SUBJECTIVE

Age: _____ **When did your symptoms start?** _____

Hand Dominance: ☐ Right ☐ Left **Date of next Doctor's appointment:** _____

Describe the current problem that brought you here: _____

_____

Are your symptoms: ☐ Improving ☐ Getting Worse ☐ Staying the Same

Have you had any testing? ☐ X-rays ☐ MRI ☐ EMG/ Nerve Conduction Test ☐ CT Scan

☐ Other **Results:** _____

Have you ever had these symptoms before? ☐ Yes ☐ No **Description:** _____

Have you ever had treatment before for these symptoms? ☐ Yes ☐ No **If Yes, please describe:**

☐ **Medication:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Injection:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Physical Therapy:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

☐ **Massage/Chiropractic:** **Beneficial?** ☐ Yes ☐ No **Explain:** _____

Did you have surgery? ☐ Yes ☐ No **Date of Surgery:** _____

If yes, what procedure did you have done? _____

Have you ever purchased or rented Durable Medical Equipment, Orthotics, Prosthetics, or Supplies?

☐ Yes ☐ No **Explain:** _____

THERAPIST COMMENTS:

CURRENT COMPLAINTS

If you have pain, what is your pain level?

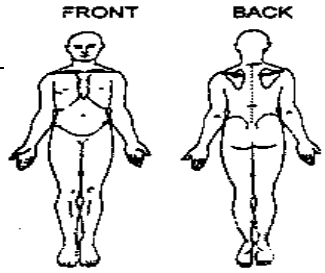
(0 = No Pain, 10 = Extreme Pain – Circle)

AT WORST: 0 1 2 3 4 5 6 7 8 9 10

AT BEST: 0 1 2 3 4 5 6 7 8 9 10

CURRENTLY: 0 1 2 3 4 5 6 7 8 9 10

Mark the location of your pain with an "X":



Are your symptoms: ☐ Constant ☐ Come and Go ☐ Ache ☐ Deep ☐ Superficial ☐ Dull ☐ Sharp ☐ Shooting ☐ Burning ☐ Numbness/Tingling ☐ Other: _____

Day Pattern:

Does your pain seem to be WORSE at a certain time of day? ☐ Yes ☐ No

If Yes, ☐ Morning ☐ Night ☐ Other:_____

Does your pain progress as the day goes along? ☐ Yes ☐ No

If Yes, please explain: _____

Do you have difficulty falling asleep? ☐ Yes ☐ No **If Yes, please explain:** _____

Do you wake due to pain? ☐ Yes ☐ No **If Yes, # of times per night:** _____

THERAPIST COMMENTS:

FUNCTIONAL ABILITIES AND RESTRICTIONS

What were you doing prior to this injury that you are unable to do currently? Please list any additional activities that you are having difficulty completing. _____

☐ Squatting ☐ Sitting ☐ Driving ☐ Reaching ☐ Work Tasks ☐ Gripping/Pinching
☐ Standing ☐ Walking ☐ Lifting ☐ Dressing/Grooming ☐ Stairs ☐ Position Changes
☐ Kneeling ☐ Holding/Carrying Objects
☐ Other: _____

What activities make your pain WORSE? _____

What activities make your pain BETTER? _____

What household duties are you having difficulty performing? ☐ Cooking ☐ Cleaning ☐ Vacuuming
☐ Laundry ☐ Yard Work ☐ Grocery Shopping ☐ Other: _____

Do you use an assistive device? ☐ None ☐ Cane ☐ Walker ☐ Wheelchair ☐ Other: _____

Did you use an assistive device prior to current injury/conditions? _____

Hobbies/ Interests/ Exercise: _____

THERAPIST COMMENTS:

Patient Name: _____ **Date of Birth:** _____ **Date of Eval:** _____

WORK HISTORY/ SOCIAL HISTORY/ INTERESTS/ LIVING ENVIRONMENT

Occupation: _____ **Presently Working:** ☐ **Yes** ☐ **No**

If Yes, ☐ **Full Duty** ☐ **Limited Duty: Restrictions:** _____ **# Days Off Work:** _____

Job Duties: ☐ **Sitting** ☐ **Computer Work** ☐ **Bending** ☐ **Heavy Lifting** ☐ **Traveling** ☐ **Standing** ☐ **Reaching** ☐ **Crawling** ☐ **Twisting** ☐ **Walking** ☐ **Pushing/Pulling** ☐ **Gripping/Pinching** ☐ **Other:** _____

Are you now, or have you ever been disabled (service or work)? ☐ **Yes** ☐ **No** **If Yes, when?** _____

If Yes, please explain: _____

What is your current living arrangement? ☐ **Alone** ☐ **Spouse** ☐ **Partner** ☐ **Family** ☐ **Other:** _____

Does your home have stairs? ☐ **Yes** ☐ **No** **If Yes, # of stairs:** _____

If Yes, do your stairs have handrail? ☐ **Yes** ☐ **No** **If Yes, which side going up?** ☐ **Right** ☐ **Left** ☐ **Both**

THERAPIST COMMENTS:

PREVIOUS MEDICAL HISTORY/ MEDICAL PRECAUTIONS AND CONTRAINDICATIONS

How would you classify your general health? ☐ **Good** ☐ **Fair** ☐ **Poor**

In terms of your general health, please check ALL that apply:

☐ Allergies	☐ Anemia	☐ Liver/Gallbladder Problem
☐ Rheumatoid Arthritis	☐ **Recent Fever**	☐ Fibromyalgia
☐ Metal Implants	☐ **Ringing of the Ears**	☐ Asthma/Breathing Difficulties
☐ **Recent Headaches**	☐ **Recent Nausea/Vomiting**	☐ Seizures/Epilepsy
☐ **Recent Vision Changes**	☐ Heart Attack	☐ **Recent Dizziness/Fainting**
☐ Sexual Dysfunction	☐ **Cancer**	☐ **Recent Change in Bowel/Bladder Habits**
☐ Osteoarthritis	☐ Skin Abnormalities	☐ **Pain with Cough/Sneeze**
☐ Heart Palpitations	☐ Osteoporosis	☐ Smoking History
☐ Chest Pain/Angina	☐ Hernia	☐ Pacemaker
☐ Stroke/TIA	☐ Depression	☐ High/Low Blood Pressure
☐ Physical Abnormalities	☐ Surgeries	☐ Diabetes I or II
☐ Hypoglycemia	☐ Polio	☐ **Unexplained Weight Loss/Gain**
☐ **Night Pain**	☐ Intolerance to Cold/Heat	☐ Pregnancy (Currently)
☐ Urine Leakage	☐ Recent Fractures	☐ **Recent Unexplained Fatigue**
☐ Kidney Problems	☐ Heart Disease	☐ **Numbness/Tingling in Hip/Buttocks Area**

Is there any other information regarding your medical history or are there any factors that may complicate your ability to participate in therapy that we should know about? _____

_____

_____

Have you had any falls in the past 12 months? ☐ **Yes** ☐ **No** **If Yes, how many times?** _____

If Yes, please describe the nature of the fall (s): _____

If Yes, please describe if an injury(ies) occurred: _____

_____

THERAPIST COMMENTS:
☐ **See Attached List**

MEDICATIONS

Please list all of the medications [*with specific NAME, DOSAGE, FREQUENCY, and ROUTE (ie: by mouth)*] that you are currently taking [including over-the-counter, prescriptions, herbals, and vitamins/mineral(s)]:

_____

_____

_____

THERAPIST COMMENTS:
☐ **See Attached List**

PATIENT GOALS FOR THERAPY

What are your goals for participating in Therapy? (I.E: performing household tasks without pain)

_____

_____

THERAPIST COMMENTS:

SIGNATURES

To the best of my knowledge I have fully informed you of the history of my problem and current status.

Patient's Signature: _____ **Date:** _____

Therapist's Signature: _____ **License #:** _____ **Date:** _____

Printed Therapist's Name: _____