Physical Therapy Initial Evaluation Form

Please fill out completely all items related to you and your health. This allows us to perform a more complete evaluation.

What brings you to Therapy: ______________________________ Date of Onset/Injury ______________

Did you have surgery for this condition? If yes, list date and type of surgery: ______________________________

Have you had any tests in the past year?

X-rays	☐ No	☐ Yes	Where ____________________	Month/Year ______________
MRI	☐ No	☐ Yes	Where ____________________	Month/Year ______________
CT or Other	☐ No	☐ Yes	Where ____________________	Month/Year ______________

Your Top 3 MOST Difficult Activities:

1. ____________________
2. ____________________
3. ____________________

Symptom Quality

- ☐ Aching
- ☐ Burning
- ☐ Dull
- ☐ Pulsing
- ☐ Sharp
- ☐ Shooting
- ☐ Steady
- ☐ Throbbing

Ability to Sleep

- ☐ I am able to get comfortable
- ☐ Pain wakes me after ________ hours
- ☐ Unable to get comfortable

Sleep Position ______________

Headaches?	☐ No	☐ Yes # per week ________
Numbness?	☐ No	☐ Yes Where __________
Tingling?	☐ No	☐ Yes Where __________
Dizziness?	☐ No	☐ Yes

How long can you do the following before your condition slows or stops you?

Walking time or distance:______________

Sitting minutes:____________________

Standing minutes:__________________

Other:_________________________

What are some social, sport, hobbies or other activities that your condition stops you from doing?

____

____

What have you been able to do in the last week regarding?

Reaching up/out to:______________________________

Lifting limited to:______________________________

Carrying only:______________________________

Driving distance: ______________________________

Chores: ______________________________

What do YOU do to ease your symptoms?

____

Medical History: please be complete or attach a complete list.

Active Medical Conditions

- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Arthritis
- ☐ Heart Problems
- ☐ Osteoporosis/Osteopenia
- ☐ Epilepsy or Seizures
- ☐ Diabetes
- ☐ Migraines
- ☐ Lung Problems

Prior Treatments

- ☐ Cortisone Shot(s) dates & body region ___________________________
- ☐ Massage Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Chiropractic Treatment

Medical History

- ☐ Cancer What type?________________
- ☐ Chemotherapy
- ☐ Stroke
- ☐ Heart Attack
- ☐ Dialysis
- ☐ Car accidents within the past 5 years
- ☐ Brain or spinal cord injuries
- ☐ Number of Pregnancies ____________
- ☐ Other ____________________________

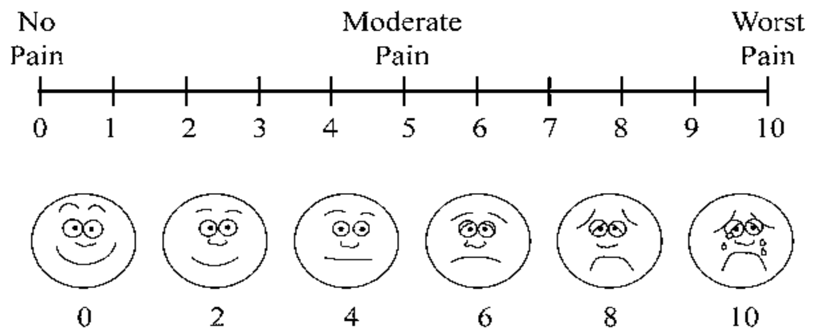
Surgical History: date and type of surgery ____
(Write in or attach) ____
____
____

Pain Scale: in the past week

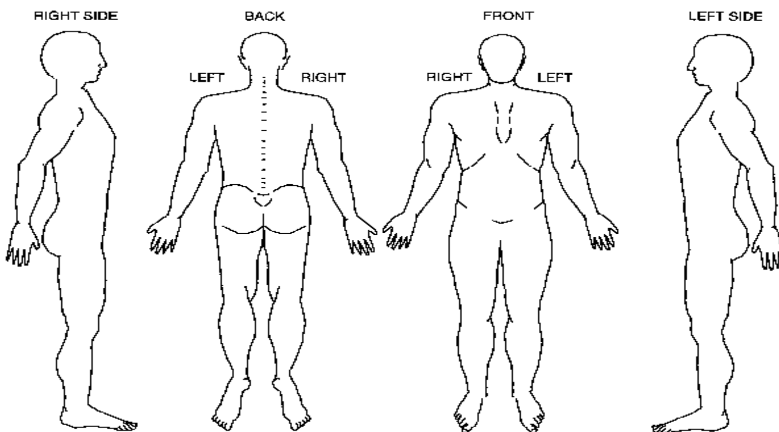
Circle your LOWEST pain

and

X your HIGHEST pain



Location: Indicate on the figures WHERE your symptom(s) are located



Any falls this past year? ☐ No ☐ Yes

Number of falls this past year ____________

Last fall was ___________________________

Cause of fall ___________________________

Height _____________Weight ______________

Patient Name____Today's Date___________________________