POWER-UP MEDICAL EXERCISE INITIAL EVALUATION FORM

CLIENT INFORMATION DATE_____

NAME_____ OCCUPATION_____
(LAST) (FIRST)

BIRTHDATE_____ AGE_____ HEIGHT_____ WEIGHT_____lbs

HOME/CELL PHONE_____ EMPLOYER_____

CURRENTLY EMPLOYED? ☐ YES ☐ NO ☐ MODIFIED

MET INFORMATION

1. CHIEF COMPLAINT/AILMENT/INJURY_____
2. DATE OF INJURY_____ DATE OF SURGERY_____
3. BRIEFLY DESCRIBE HOW YOU WERE INJURED

   _____

   _____
4. HAVE YOU RECEIVED THERAPY FOR THIS CONDITION? ☐ YES ☐ NO WHEN?_____
   HOW MANY VISITS?_____
5. HAS YOUR CONDITION BEEN GETTING: ☐ WORSE ☐ SAME ☐ BETTER
6. ARE YOUR SYMPTOMS: ☐ CONSTANT OR ☐ INTERMITTENT
7. MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

   AT BEST: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (EXCRUCIATING PAIN)

   AT WORST: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (EXCRUCIATING PAIN)
8. WHAT DECREASES/MAKES YOUR CONDITION BETTER? (MARK ALL THAT APPLY)

☐ BENDING	☐ MOVEMENT	☐ REST	☐ BETTER IN AM
☐ SITTING	☐ STANDING	☐ HEAT	☐ BETTER AS DAY PROGRESSES
☐ RISING	☐ WALKING	☐ ICE	☐ BETTER IN PM
☐ CHANGING POSITIONS	☐ LYING	☐ MEDICATION	☐ N/A CAST JUST REMOVED

9. WHAT INCREASES/MAKES YOUR CONDITION WORSE? (MARK ALL THAT APPLY)

☐ BENDING	☐ MOVEMENT	☐ REST	☐ SNEEZE
☐ SITTING	☐ STANDING	☐ STAIRS	☐ DEEP BREATH
☐ RISING	☐ WALKING	☐ COUGH	☐ MEDICATION
☐ PROLONGED POSITIONING	☐ LYING	☐ WORSE IN AM	☐ WORSE IN PM
☐ WORSE AS DAY PROGRESSES	☐ N/A CAST JUST REMOVED		

10. PREVIOUS MEDICAL INTERVENTION FOR CURRENT CONDITION (MARK ALL THAT APPLY)

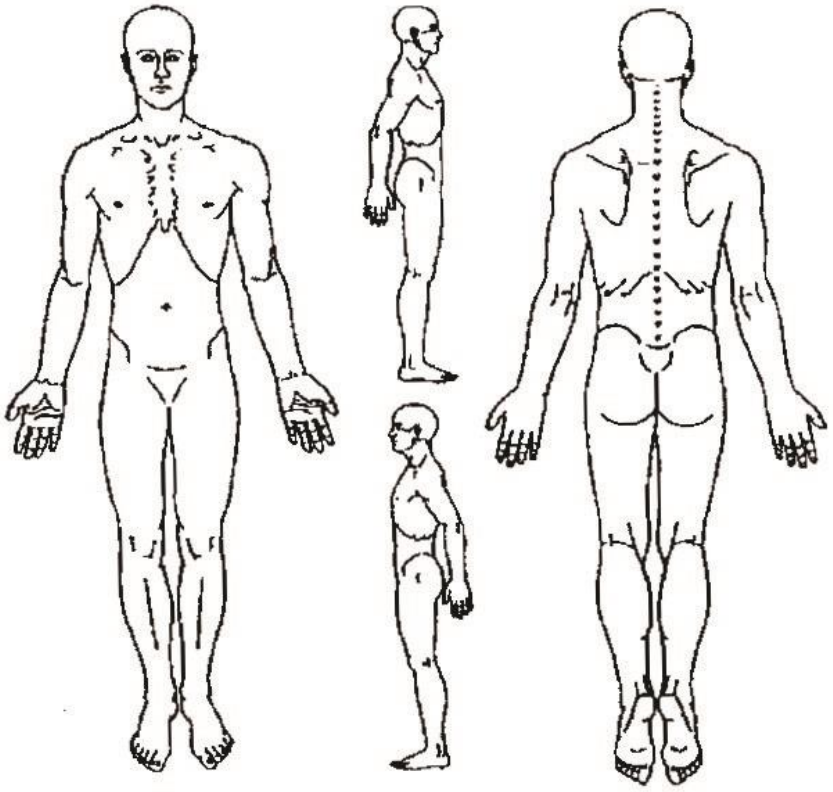
☐ X-RAY MRI ☐ CATSCAN ☐ INJECTIONS ☐ OTHER_____

11. WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF MET?

_____

_____

DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS. If you are completing this form on the computer, print form after completion and mark the diagram with a pen.



SEVERE PAIN	*******
MODERATE PAIN	00000000
DULL ACHE	∩∩∩∩∩∩
RADIATING PAIN	↑↓↑↓↑↓↑↓
NUMBNESS/TINGLING	XXXXXX

MEDICAL INFORMATION (MARK ALL THAT APPLY) **THIS INFORMATION IS CONFIDENTIAL AND REMAINS PART OF YOUR CHART

☐ DIFFICULTY SWALLOWING	☐ MOTION SICKNESS	☐ STROKE
☐ ARTHRITIS	☐ FEVER/CHILLS/SWEATS	☐ OSTEOPOROSIS
☐ HIGH BLOOD PRESSURE	☐ UNEXPLAINED WEIGHT LOSS	☐ ANEMIA
☐ HEART TROUBLE	☐ BLOOD CLOTS	☐ BLEEDING PROBLEMS
☐ PACEMAKER	☐ SHORTNESS OF BREATH	☐ HIV/HEPATITIS
☐ EPILEPSY/SEIZURES	☐ HISTORY OF SMOKING	☐ HISTORY OF ALCOHOL ABUSE
☐ HISTORY OF DRUG ABUSE	☐ DIABETES	☐ DEPRESSION/ANXIETY
☐ MYOFASCIAL PAIN CANCER	☐ FIBROMYALGIA	☐ PREGNANCY

PREVIOUS SURGERIES:_____

MEDICATIONS:_____

_____

ALLERGIES:_____