



INITIAL EVALUATION

Name: _____ Date _____ Age: _____
Physician: _____ Diagnosis: _____
Occupation: _____ Sport/Activity: _____
Physical Demands of the job? _____

Please indicate for which body part you are seeking treatment. (Please circle) L R
Neck Mid Back Low Back Shoulder Elbow Hand/Wrist Hip Knee Ankle/foot
Other _____

Date of injury/onset/surgery: _____

What was the cause of your complaint? _____

Have you ever had similar complaints in the past? _____

What is your chief complaint now? _____

Have you had previous therapy? When? _____ Kind of therapy: _____

Have you had recent tests? MRI Xrays CT Scan Bone Scan EMG Other _____
(Circle) _____

Any medical problems? (Circle) High Blood Pressure, Diabetes, Arthritis, Cancer,
Allergies, Pace Maker, Stroke, Pregnancy, Other _____

Current Medications: _____

Pain rating: Indicate your average level of pain by circling the appropriate number on the scale:

0 1 2 3 4 5 6 7 8 9 10
mild moderate extreme agony

Does your pain?(circle) Throb Burn Stab Ache Other _____

Is your pain present all the time? Yes _____ No _____

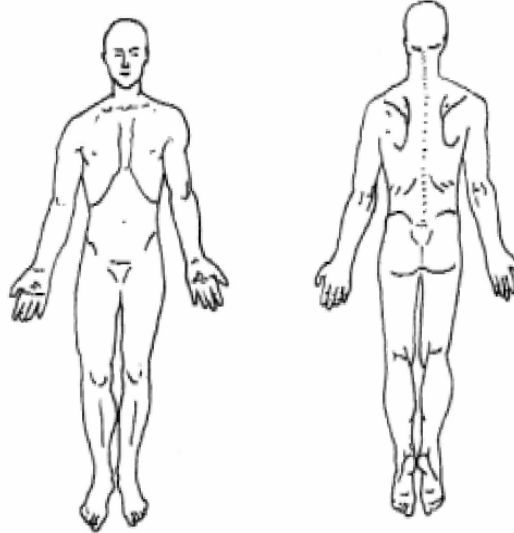
Does your pain move or radiate anywhere ? If yes where to? _____

Do you have numbness,tingling,or weakness? If yes where _____

TURN OVER PAGE

Using the appropriate symbols, mark on the body diagram where you feel the following sensations:

Numbness Pins and Needles Burning Stabbing Aching
== ooo xxx /// ***



Please mark (with an X) on the line indicating how bad your pain is now:

No Pain ----- Worst Possible Pain

What activities/positions make your pain worse? _____

What activities/positions make your pain better? _____

What is your goal for your treatment? _____

What activity/ hobby or sport would you like to resume. _____

When is your next Dr. appt.? _____

Patient Signature: _____ Date: _____

FOR THERAPIST USE ONLY

COMMENTS:

Initial Evaluation: _____

THERAPIST SIGNATURE _____ DATE _____