Patient#_______________ Provider_______

PHYSICAL THERAPY INITIAL EVALUATION FORM

PATIENT INFORMATION DATE____________________

NAME____ OCCUPATION____
(LAST) (FIRST)

BIRTHDATE______________________ AGE______ HEIGHT____________ WEIGHT________lbs

HOME/CELL PHONE__________________________________ EMPLOYER____

CURRENTLY EMPLOYED? O YES O NO O MODIFIED

REHAB 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? O YES O NO WHEN?______________________

HOW MANY VISITS?___________

5. HAS YOUR CONDITION BEEN GETTING: O WORSE O SAME O BETTER

6. ARE YOUR SYMPTOMS: O CONSTANT OR O INTERMITTENT

7. MARK THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN:

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

AT WORST: O 0 O 1 O 2 O 3 O 4 O 5 O 6 O 7 O 8 O 9 O 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 (MARK ALL THAT APPLY)

☐ X-RAY MRI ☐ CATSCAN ☐ INJECTIONS OTHER____

COZY
PHYSICAL THERAPY

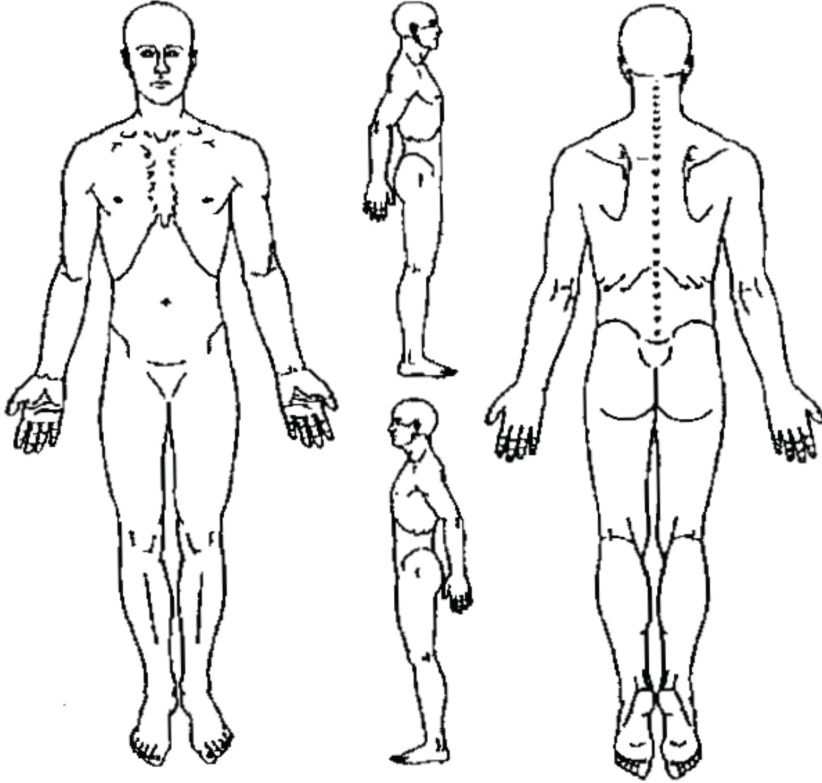
Patient#________________ Provider_______

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

____

____

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
☐ ARTHRITIS
☐ HIGH BLOOD PRESSURE
☐ HEART TROUBLE
☐ PACEMAKER
☐ EPILEPSY/SEIZURES
☐ HISTORY OF DRUG ABUSE
☐ MYOFASCIAL PAIN
☐ CANCER

☐ MOTION SICKNESS
☐ FEVER/CHILLS/SWEATS
☐ UNEXPLAINED WEIGHT LOSS
☐ BLOOD CLOTS
☐ SHORTNESS OF BREATH
☐ HISTORY OF SMOKING
☐ DIABETES
☐ FIBROMYALGIA

☐ STROKE
☐ OSTEOPOROSIS
☐ ANEMIA
☐ BLEEDING PROBLEMS
☐ HIV/HEPATITIS
☐ HISTORY OF ALCOHOL ABUSE
☐ DEPRESSION/ANXIETY
☐ PREGNANCY

PREVIOUS SURGERIES:____

OTHER:____

MEDICATIONS:

____

____

ALLERGIES:____