To assist your therapist with the evaluation, please fill out the form below. If you do not understand a question, your therapist will assist you. Thank you for your time.

Today's Date: _______________ Name:______________________________ Date of Birth: ___________________

Gender Identity: _____________________________________ Preferred Pronouns: __________________________

Next Doctor's Appointment: _______________ Employer and Occupation: __________________________________

Presently working? ☐YES ☐NO If no, last day worked? __________________

☐Right handed ☐Left handed

What type of problem brings you to the clinic? ____

Injured how? ____ Date of onset: ______________

Previous treatment for this condition: ____

Current treatments for current or prior conditions: ☐physical therapy, ☐chiropractic, ☐massage, ☐ other: _________

____

What are your goals for therapy? ____

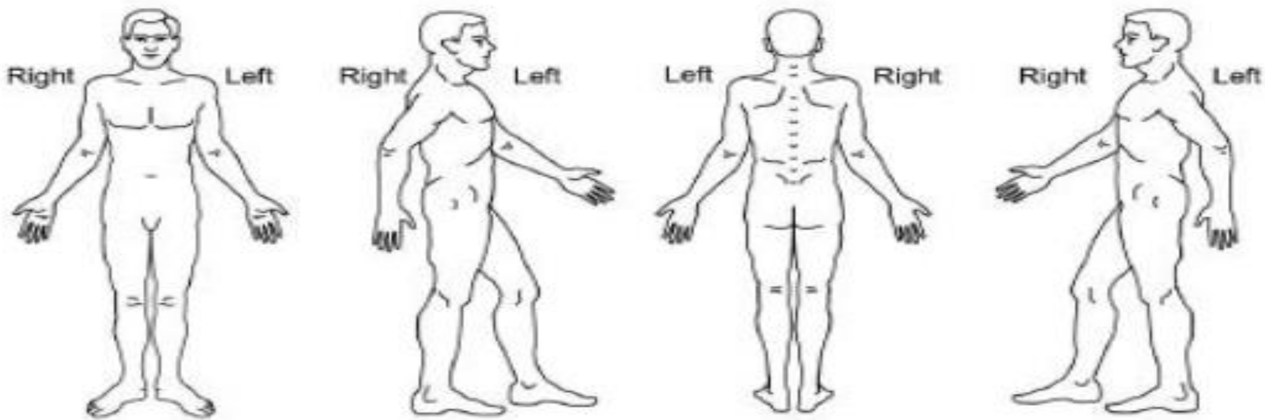
Pain Assessment: Describe your pain today: ____

____

Pain pattern: ☐Constant or ☐Intermittent Pain quality: ☐Sharp ☐Dull ☐Aching ☐Burning

Place a vertical mark on the line below to indicate your least, average and worst pain scores:

Shade in the figures below to indicate where your pain is located.



Top 3 Limitations:

Activity **Rating 0 (Unable) to 10 (No Difficulty)**

1.____

2.____

3.____

Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada, 47, 258-263.

Please continue to page 2

GO! PHYSICAL THERAPY

LIST OVER-THE-COUNTER and PRESCRIBED medications you are currently using (including pills, injections, and/or skin patches) - please attach or provide list: ______________________________

____

____

Have you **EVER** been diagnosed as having any of the following conditions?

Cancer YES NO If **YES**, describe what kind: ______________________________

Heart problems	YES	NO	Asthma	YES	NO	Fibromyalgia	YES	NO
Pacemaker	YES	NO	Tuberculosis	YES	NO	Thyroid problems	YES	NO
High blood pressure	YES	NO	Emphysema/Bronchitis	YES	NO	Hearing loss	YES	NO
Stroke	YES	NO	Kidney disease	YES	NO	Headaches/Migraines	YES	NO
Neurological disorder	YES	NO	Hepatitis	YES	NO	Epilepsy	YES	NO
Rheumatoid Arthritis	YES	NO	Diabetes	YES	NO	History of MRSA	YES	NO
Other arthritic conditions	YES	NO	Anemia	YES	NO	History of Clostridium difficile (C-diff)	YES	NO
Osteoporosis	YES	NO	Depression	YES	NO			

Other: ______________________________

Allergies: ______________________________

Previous Diagnostic Tests: ☐X-ray ☐Ultrasound ☐MRI ☐CT scan ☐bone scan Other: ______________

List any relevant surgery or injury that you have had:

Date	Injury/Surgery	How was it treated

Do you use:	Tobacco	YES	NO	Caffeine (soda/coffee)	YES	NO
Recently noticed:	Weight loss/gain	YES	NO	Fatigue	YES	NO
	Nausea/Vomiting	YES	NO	Weakness	YES	NO

How do you best learn? ☐Pictures ☐Reading ☐Listening ☐Demonstration

☐Other ______________________________

____

______________________________ ______________________________

Therapist's signature Date Time