TheraPhysical

PATIENT INFO

Last Name _____First Name _____ Age _____ Gender _____ Male _____ Female

Occupation _____ Phone _____

IN ORDER TO EVALUATE YOUR CONDITION FULLY, PLEASE BE AS ACCURATE AS POSSIBLE.

1. Have you had physical therapy before?_____ No _____ Yes: when _____

2. Have you had Home Health Care? _____ No _____ Yes: when _____

3. Where is your pain/injury? _____

4. What caused your pain/injury? _____

5. Approximately when did the pain/injury start? _____

6. Is the pain/injury getting? _____ Worse _____ Better _____ Staying the Same

7. Have you ever had this pain/injury before? _____ No _____ Yes: when _____

8. Is your pain? _____ Constant (never goes away) _____Intermittent (comes and goes)

9. On a scale from zero to ten, circle your worst pain level in the past couple of days 0 1 2 3 4 5 6 7 8 9 10

10. Are you taking any medication for this pain/injury? _____ No _____ Yes: what kind, does it help _____

_____

11. Are any of your usual everyday activities affected? _____ No _____ Yes: describe how_____

_____

12. List all past surgeries with dates _____

_____

13. List all medical conditions you have _____

_____

14. Other important information we should know about _____

_____

Patient Signature _____ **Date** _____

INITIAL EVALUATION

Physical Therapist _____ Initials _____ Date _____