Initial Evaluation Subjective Report

Date: _____

Name: _____

Age: _____ Height: _____ Weight: _____ (REQUIRED BY INSURANCE)

Preferred to be called:_____

Email Address: _____

Occupation: _____ Hours per week: _____

Referring Physician: _____

THE FOLLOWING IS VERY IMPORTANT IN OUR EVALUATION PROCESS. PLEASE FILL OUT THESE FORMS AS SPECIFICALLY AS POSSIBLE TO PROVIDE US WITH A CLEAR PICTURE OF YOUR PRESENT FUNCTIONAL ABILITY AND SYMPTOMS.

1. WHAT ARE YOUR GOALS FOR PHYSICAL THERAPY?

2. Please list the main activities and/or positions that increase your symptoms.

3. Rate your pain level on the scale below with **10** representing the highest level and **0** being no pain.

Pain on most days 0----5----10 Today's Pain: 0-----5-----10

4. What is your primary complaint that brings your to Specialized Physical Therapy? Please describe your symptoms as specifically as possible.

Secondary Complaint?

5. On what date did your symptoms begin? _____

6. How did your symptoms begin? For example, did your symptoms begin as a result of an accident or trauma or did they begin without a known reason?

7. How frequent are your symptoms?

8. What relieves your symptoms?

9. Circle any/all of the following medical conditions that apply to you.

Circulatory problems	High Blood Pressure	Heart Trouble	Pacemaker	Epilepsy
Bowel/Bladder Problems	Pregnancy	Blackouts	Headaches	Stroke
Visual Disturbances	Diabetes	Weight Changes (>15lbs)	Ringing in Ears	Malignancy

10. Past Medical History: Please list any surgeries, accidents or other conditions and the dates that you have had throughout your life.

11. Have your ever received the following treatment for your current condition?

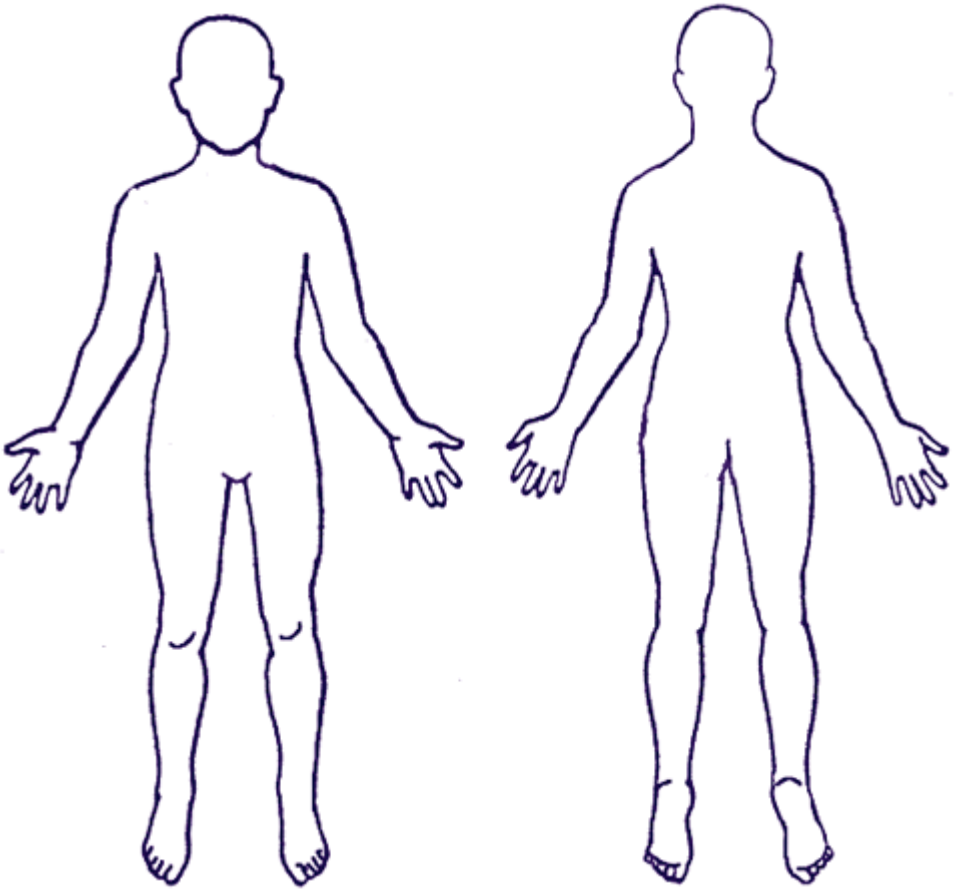
Treatment	Yes	No	How long?	Helpful?
Physical Therapy				
Myofascial Release				
Other (i.e. Chiropractor, Massage Therapist, etc.)				

MEDICATIONS:

Please indicate below ALL medications you are currently taking.

Medications	For treatment of	Dose/Amt/Day	Effectiveness

PLEASE SHADE AREAS OF PAIN ON THE DIAGRAM BELOW:



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