

Physical Therapy Evaluation History

Date: _____ Age: _____

Name: _____ Height: _____ Weight: _____

Date of your next appointment with your physician _____

Date of injury _____

Injury/illness description and how it began: _____

Have you had this injury or illness before? Yes No

Have you had any surgery related to this problem? Yes No Date / /

If yes, briefly describe _____

Occupation _____

Are you currently working? Yes No

If yes, are you under any work restrictions? _____

Have you had other treatment for this problem?

Medications	Chiropractic Care
Previous Physical Therapy	Injections
Home Exercises	Other: _____

If so, please describe: _____

Special Tests/Results (i.e. X-ray, EMG, MRI, Arthrogram, CT Scan, Blood Tests, etc.) _____

What limitations do you now have due to this condition in your day to day activities, or occupational tasks? _____

Please describe your personal goals in attending physical therapy: _____

Please complete all 3 pages of this form.

Please mark all that apply to your current or past medical history.

- Yes No High blood pressure
- Yes No Cardiac problems, including pacemakers
- Yes No Respiratory conditions, allergies, or asthma
- Yes No Diabetes
- Yes No Cancers, malignancies, or tumors
- Yes No Rheumatoid arthritis
- Yes No Osteoarthritis
- Yes No Allergy to bee stings
- Yes No Weight loss or gain
- Yes No Bowel or bladder problems
- Yes No Pregnant

Other: _____

Please complete all 3 pages of this form.

Mark Area of Involvement

Time of day least pain: _____

Time of day worst pain: _____

On a scale from 0 to 10, describe your pain over the past week.

Least Pain: 0 1 2 3 4 5 6 7 8 9 10

Worst Pain: 0 1 2 3 4 5 6 7 8 9 10

Pain Today: 0 1 2 3 4 5 6 7 8 9 10

