

## 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

