Self-Evaluation Form

Name: ______________________________ Date: ___/___/___ Date of Discomfort and/or Surgery: ___/___/___

Area of discomfort: _______________________________________ Referring Physician: _________________________

Tell us how you hurt yourself? ____

____

Please list for us the things you are having difficulty with related to your current discomfort:

1. ____

2. ____

3. ____

4. ____

5. ____

Pain circle your pain from BEST to WORST: 0 1 2 3 4 5 6 7 8 9 10 (0- No Pain, 10-Extreme Pain)

Pain Description (Circle all that apply): Dull/Achy Burning Throbbing Sharp Shooting Numbness

What makes your pain better or worse?: ____

Please check any condition listed below that applies/has applied to you:

- Contagious skin condition
- Open sores or wounds
- Phlebitis
- Epilepsy
- Easy Bruising
- Recent accident or injury
- Recent Fracture
- Recent Surgery
- Tennis Elbow
- Joint disorder
- Arthritis
- Cancer (currently under

- Artificial joint
- Sprains/Strains
- Current Fever
- Swollen Glands
- High or Low Blood Pressure
- Allergies/sensitivities
- Heart Condition
- Varicose veins
- Circulatory Disorder
- Atherosclerosis
- Pregnancy (if yes how many months? ____________

- Headaches/Migraines
- Osteoporosis
- Deep Vein Thrombosis
- Blood clots
- Diabetes
- Tendonitis
- Decreased Sensation
- Back or Neck Problems
- Fibromyalgia
- TMJ
- Carpal Tunnel Syndrome joint disorder

Diagnostic Tests/Images: ____

Surgical History: ____

Current Vitamins/Medications: ____

Are you currently under the care of a physician, psychiatrist or other health care professional other than the one who prescribed your physical therapy? O Yes O No

Have you ever had physical therapy/chiropractic or body work prior to this occasion? O Yes O No

If yes, what, when and how much:____

Patient Signature: ______________________________ Therapist Signature: ______________________________

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