Integrative Physical Therapy,Inc.

Initial Evaluation / Subjective Report

Name:_____ Date:_____

***** INSURANCE COMPANIES ARE NOW REQUIRING DETAILED INFORMATION REGARDING YOUR CONDITION. THE FOLLOWING INFORMATION IS VERY IMPORTANT TO OUR EVALUATION PROCESS.***

Please be specific and as detailed as possible to provide us with a clear picture of your condition and functional status.

1. **What are your current complaints?**

   _____

   _____

   _____

2. **When did your symptoms begin, or injury occur?**_____

3. **How did it occur?** (if known) _____

   _____

4. **If this is a chronic condition, have you experienced a flare up or recent change in your condition?** *(and when?)*_____

5. **Description of Symptoms/Pain:** (Choose all that apply)

   ☐ **Constant** ☐ **Intermittent** ☐ **Sharp** ☐ **Shooting** ☐ **Throbbing**

   ☐ **Burning** ☐ **Dull/Achy** ☐ **Cramping** ☐ **Other** _____

Check one: Getting progressively worse ___ Staying the same ___ Getting better ___

6. **Pain Level** (on scale of 0-10) **0= No Pain 5= Moderate 10= Worst Pain Imaginable**

NOW:	0	1	2	3	4	5	6	7	8	9	10
BEST:	0	1	2	3	4	5	6	7	8	9	10
WORST:	0	1	2	3	4	5	6	7	8	9	10

7. Circle any of the following that makes your pain worse:

sitting standing walking going up stairs / down stairs bending sit to stand
lying down cough/sneeze am pm as day progresses other_____

8. Symptoms are better with: (circle all that apply)

standing walking sitting lying bending am pm
as the day progresses when still while moving other_____

9. Tolerance for the following: (before having to get up or change positions)

	0-10 min	15 min	30 min	45 min	1 hr	2 hr	3-4 hr	No Problem
Sitting	☐	☐	☐	☐	☐	☐	☐	☐
Standing	☐	☐	☐	☐	☐	☐	☐	☐
Walking	☐	☐	☐	☐	☐	☐	☐	☐

10. Limitations <u>prior</u> to current condition
(please circle)

Sleep
Self care (dressing/bathing)
Activities of Daily Living
Reaching / Pulling / Pushing
Lifting / Carrying
Sitting / Standing
Bending / Squatting
Mobility / Walking
Community Access / Driving
Going up/down stairs
Work related activities
Recreational activities

Current Limitations
(please circle)

Sleep
Self care (dressing/bathing)
Activities of Daily Living
Reaching / Pulling / Pushing
Lifting / Carrying
Sitting / Standing
Bending / Squatting
Mobility / Walking
Community Access / Driving
Going up/down stairs
Work related activities
Recreational activities

11. Do you engage in regular exercise? Yes No If applicable, what kind? _____

12. Rate your current energy level: Poor Fair Good

13. WHAT ARE YOUR GOALS FOR THERAPY? Include activities you would like to be able to do or perform better?_____

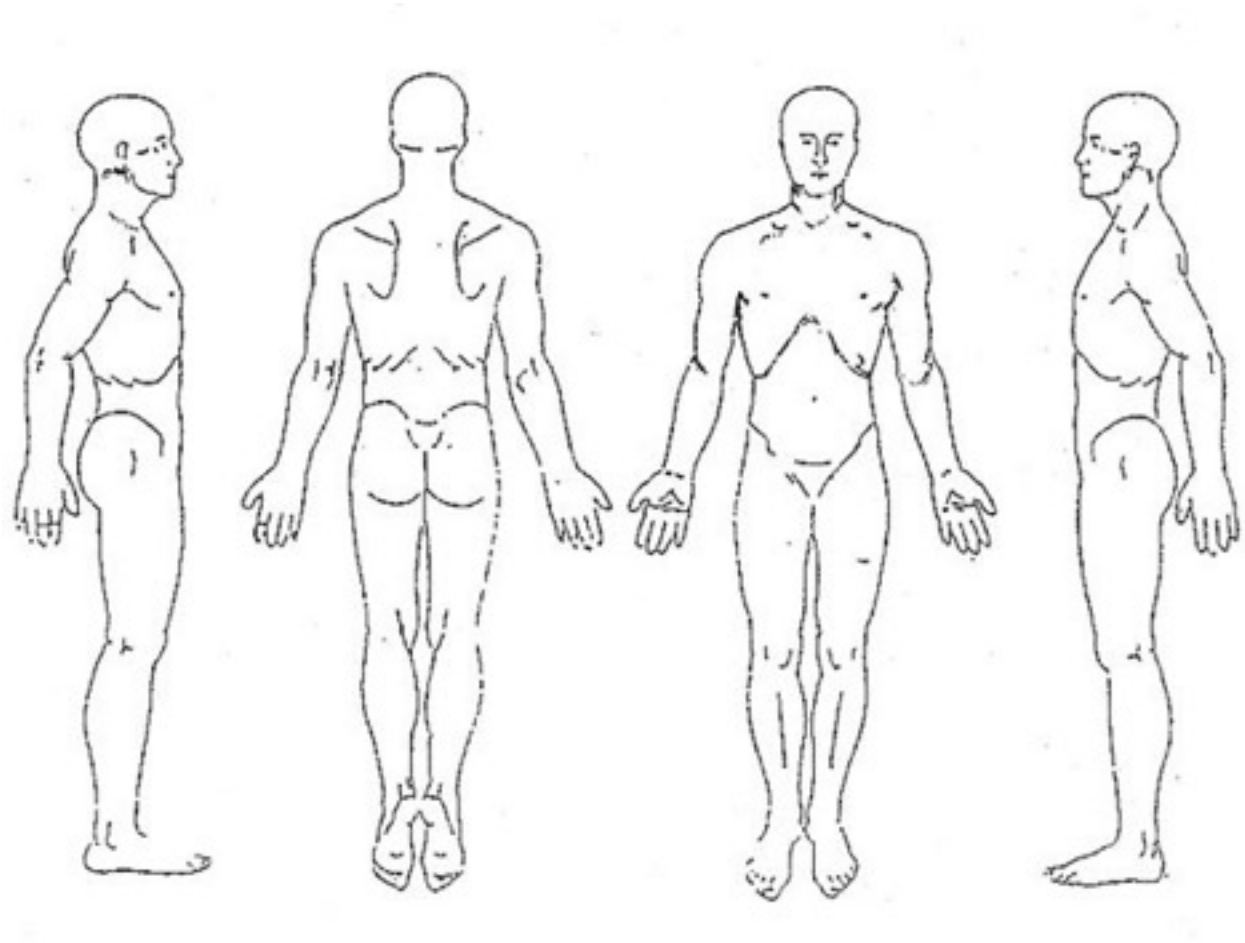
_____

_____

_____

PLEASE CIRCLE OR SHADE ANY PAIN AREAS. If you have symptoms in multiple areas, please note the level of pain out to the side. You may use the symbols below to describe the pain or sensations.

	NONE	MILD			MODERATE				SEVERE		
PAIN LEVEL:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**



A= ACHING **B= BURNING** **N=NUMBNESS** **P= PINS &NEEDLES**

S= SHARP/STABBING **T= TENDER** **O= OTHER**

MEDICAL HISTORY FORM

NAME: _____ **DATE:** _____

Check the box if you have any of the following medical conditions.

_____ Osteoarthritis	_____ Headaches	_____ Osteoporosis
_____ Rheumatoid arthritis	_____ Migraines	_____ Blood clots
_____ Cardiovascular disease	_____ TMJ / jaw pain	_____ Stroke
_____ Auto immune disease	_____ Ringing in ears	_____ Cancer: _____
_____ Frequent urination	_____ Lung disease	_____ Diarrhea
_____ Incomplete urination	_____ Asthma	_____ Constipation
_____ Bladder leakage	_____ Diabetes	_____ Menstrual difficulties
_____ Circulatory problems	_____ Hypertension	_____ Pain with sex

_____ Other conditions or illnesses: _____

_____ Recent Hospitalization: _____

Is there a chance you may be PREGNANT at this time? YES NO N/A

Current Diagnostic studies and results:

X-Rays_____

MRI _____

Surgical History: (Include dates) _____

_____

History of Falls: _____

_____

Past Injuries: _____

_____

Name:		Date:

Please list all current medications and supplements you are taking

Drug/Supplement	Dosage	How Often
EXAMPLE: Nexium	40mg	1x day
EXAMPLE: Fish Oil	1000mg	1x day