PATIENT SELF-EVALUATION

Name_____ **Date**_____

Medical History: Please check under Yes or No, if you currently have or have had any of the following:

	Yes	No		Yes	No		Yes	No
Currently/Possibly Pregnant	☐	☐	Heart Disease	☐	☐	Hepatitis (Type)	☐	☐
Pacemaker	☐	☐	Chest Pain or Palpitations	☐	☐	Tuberculosis	☐	☐
Surgically Implanted Device	☐	☐	Lung Disease	☐	☐	Dizziness / Fainting	☐	☐
If "Yes", what kind and where:			Headaches	☐	☐	Arthritis	☐	☐
_____			Diabetes	☐	☐	Etoh (Alcohol) Use	☐	☐
Cancer	☐	☐	Latex Allergy	☐	☐	Incontinence	☐	☐
High Blood Pressure	☐	☐	HIV/AIDS	☐	☐	Fear of Water	☐	☐
Any current or previous history of paralysis or neurological disorders?				☐	☐	Open Wounds	☐	☐
Are you currently taking a blood thinner or aspirin?				☐	☐			
Any current use or previous history of smoking?				☐	☐			

If quit, when?_____

List current medications, herbs, and/or over-the-counter drugs you are taking: _____

_____

Any Allergies? _____

List other medical problems and/or prior surgeries with the year they occurred: _____

_____

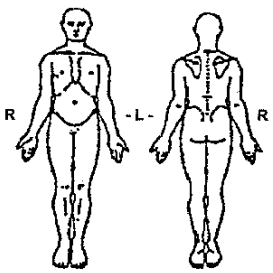
REASONS FOR PHYSICAL THERAPY

What is your main complaint (i.e. pain, radiating pain, numbness, decreased mobility, problems with activities)?

_____

Where is your main complaint located? (Mark on figure)

_____



What caused this problem/pain?

_____

_____

When did this problem/pain begin? _____.

Recent diagnostic tests (X-rays, MRI, etc.): _____

_____

Are you currently employed? ☐Yes ☐No Job Title: _____How many years at your present job? _____

Last Day of Work: _____ Currently on Medical Leave or Light Duty? ☐Yes ☐No

If yes, please specify: _____

Was this a work-related injury? ☐Yes ☐No_____

Have you had previous therapy/treatment for this problem? ☐Yes ☐No Was it beneficial? ☐Yes ☐No

If yes, what was the treatment? _____

Have you had surgery for this problem? ☐Yes ☐No Date: _____

Have you ever had a similar injury? ☐Yes ☐No

Any special instructions or restrictions from your doctor? _____

_____

What are your goals for treatment? _____

Do you have any objection to your attendant being of the opposite sex? ☐Yes ☐No

Do you object to having your exercises done in an open gym with other patients? ☐Yes ☐No

_____Reviewed by: _____

Patient Signature Physical Therapist Signature