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 / Defibrillator	☐	☐	Chest Pain or	☐	☐	Neurological disorder	☐	☐
High Blood Pressure	☐	☐	Palpitations Lung	☐	☐	Dizziness / Fainting	☐	☐
Cancer	☐	☐	Disease Headaches	☐	☐	Arthritis	☐	☐
History of Smoking	☐	☐	Diabetes	☐	☐	Open Wounds	☐	☐
			Latex Allergy	☐	☐	Incontinence	☐	☐
If quit, when? _____			HIV/AIDS	☐	☐	Fear of Water	☐	☐

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: _____

_____

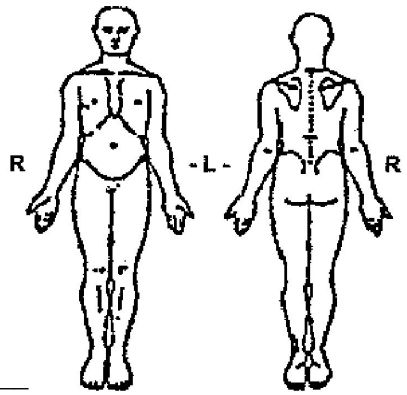
Surgically Implanted Device Yes / No If yes, describe _____

REASONS FOR PHYSICAL THERAPY

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

_____

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.): _____

_____

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? _____

Was this a work-related injury? Yes / No

Currently on Medical Leave or Light Duty? Yes / No

If yes, please specify: _____

X_____

Patient Signature